02316

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH · COUNTY: Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Dorchester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville — LENGTH OF STAY (in this place): 2yrs. 10 mons.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cambridge
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital	STREET ADDRESS (If rural, give location): 59 Hubbard Street

3. NAME OF DECEASED (Type or Print)	(First) William	(Middle)	(Last) Anderson	4. DATE OF DEATH	(Month) 3	(Day) 3	(Year) 1950
5. SEX: Male	6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 1897	9. AGE last birthday: 53 yrs.	If under 1 year: Months. Days	If under 24 hrs.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer-Fisherman	10b. KIND OF BUSINESS OR INDUSTRY: ------	11. BIRTHPLACE (State or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.				
13. FATHER'S NAME: Dan Anderson	14. MOTHER'S MAIDEN NAME: Unknown						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ---- (If year, give war or dates of service) ---	16. SOCIAL SECURITY NO. ------	17. INFORMANT: Hospital Records					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) General Paresis	Known to us since adm. 5/19/47
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

0.25x

30b

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: ------	19b. MAJOR FINDINGS OF OPERATION: ------	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify) ----	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) --	(CITY OR TOWN) (COUNTY) (STATE) ------
TIME OF INJURY (Month) (Day) (Year) (Hour) ------ m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? ------

22. I hereby certify that I attended the deceased from May 19, 1947, to March 3, 1950, that I last saw the deceased alive on March 3, 1950, and that death occurred at 8:25 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Jacob Marquette M.D.		Crownsville, Maryland	3/3/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE 3/9.50	NAME OF CEMETERY OR CREMATORY: Crownsville Hospl	LOCATION (City, town, or county) (State): Crownsville Md
DATE REC'D BY LOCAL REG. 3/9.50	REGISTRAR'S SIGNATURE: E F Joyce Local Reg	24. FUNERAL DIRECTOR: Supt Hospital	ADDRESS: Crownsville Md

988 V1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 13 1950
BUREAU V. S.

02317

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH· COUNTY Anne Arundle MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED· STATE Maryland. COUNTY A.A.Co
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severna Park — LENGTH OF STAY (in this place) 18 mos.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severna Park.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Box 143 Severn Hgts Severna Pk.	STREET ADDRESS (If rural give location) Box 143

3. NAME OF DECEASED (Type or Print) (First) Oliver (Middle) (Last) Barrett			4. DATE OF DEATH (Month) 3 (Day) 15 (Year) 1950	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, ~~MARRIED~~, WIDOWED, ~~DIVORCED~~, (Specify) Married	8. DATE OF BIRTH 2-29-1874	9. AGE last birthday 76 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Merchant	10b. KIND OF BUSINESS OR INDUSTRY Retail Food		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Thomas P. Barrett			14. MOTHER'S MAIDEN NAME Elizabeth Spanberg	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO — (If yes, give war or dates of service) —	16. SOCIAL SECURITY NO. —		17. INFORMANT Edna Brearley	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
140 Immediate cause	(a) Innanition & Malnutrition	3 wks.
450 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Squamous Carcinoma of lip c̄ Metastasis.	10 yrs.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —	19b. MAJOR FINDINGS OF OPERATION —	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-24, 1949, to 3-14, 1950, that I last saw the deceased alive on 3-14, 1950, and that death occurred at 8:30 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Charles R. MacDonald	M.D.	Glen Burnie, Maryland	3-15-50

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify)	DATE THEREOF 3/20/50	NAME OF CEMETERY OR CREMATORY Oak Lawn Cem.	LOCATION (City, town, or county) (State) Eastern Ave
DATE REC'D BY LOCAL REG. 3-17-50	REGISTRAR'S SIGNATURE A. W. Hedrick	24. FUNERAL DIRECTOR James H. Lyons	ADDRESS

15679

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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02318

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH· COUNTY: Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED· STATE: Maryland COUNTY: Balt. City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville — LENGTH OF STAY (in this place): 9 mos.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital	STREET ADDRESS (If rural, give location): 904 W. Lexington St.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Laurence Bass			4. DATE OF DEATH (Month) (Day) (Year): 3/9/50 19	
5. SEX: male	6. COLOR OR RACE: colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married	8. DATE OF BIRTH: July 30, 1895	9. AGE last birthday: 54 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waiter	10b. KIND OF BUSINESS OR INDUSTRY: B.&O. none R.R.	11. BIRTHPLACE (State or foreign country): South Caroline	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: not known		14. MOTHER'S MAIDEN NAME: not known		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): WW#1 (If year, give war or dates of service): WW#1	16. SOCIAL SECURITY No.: not known	17. INFORMANT AND ADDRESS: Hospital Records		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) General Paresis	known
Antecedent cause(s)		since
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	6/3/49

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II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none	19b. MAJOR FINDINGS OF OPERATION: none	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify): none	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE): none	
TIME OF INJURY (Month) (Day) (Year) (Hour): none m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from 6/3/49, 19....., to 3/9/50, 19....., that I last saw the deceased alive on 3/9/50, 19....., and that death occurred at 5:31 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Jacob Morgenstern M.D.		Crownsville, Md.	3/10/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: 3/16/50	NAME OF CEMETERY OR CREMATORY: Balto Nail Cem.	LOCATION (City, town, or county) (State): Balto Md
DATE REC'D BY LOCAL REG.: 3-15-50	REGISTRAR'S SIGNATURE: E. W. Hedrick	24. FUNERAL DIRECTOR: Chas. H Cooper	ADDRESS: 512 Carrollton Av.

78047

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

02319

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Anne Arundel; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Davidsonville
LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: nr M.Hardesty's Farm

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Davidsonville
STREET ADDRESS (If rural give location): Davidsonville Post Office

3. NAME OF DECEASED (Type or Print): (First) CHARLES (Middle) H. (Last) BASSFORD

4. DATE OF DEATH: (Month) March (Day) 6, (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: Nov 8,1882

9. AGE last birthday: 68 yrs. If under 1 year Months: 3 Days: 10 If under 24 hrs. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming

10b. KIND OF BUSINESS OR INDUSTRY: owner

11. BIRTHPLACE (State or foreign country): Davidsonville , Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles C. Bassford

14. MOTHER'S MAIDEN NAME: Laura Jane Talbott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Daughter
Mrs John Lowman Davidsonville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) CORONARY THROMBOSIS — Interval Between Onset and Death: ?

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the under lying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: farm
(CITY OR TOWN): Davidsonville (COUNTY): Anne Arundel (STATE): Md.
TIME OF INJURY (Month) (Day) (Year) (Hour): 3-6-50 4:45 p m.
INJURY OCCURRED While at work ☒ Not while at work ☐
HOW DID INJURY OCCUR?: Natural Causes

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: Elmer G. Linhardt (Degree or title): MD ADDRESS: 3 Chesapeake Ave. Eastport, Md. DATE SIGNED: 3-6-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: March 9,1950
NAME OF CEMETERY OR CREMATORY: Davidsonville Methodist
LOCATION (City, town, or county) (State): Davidsonville, Maryland

DATE REC'D BY LOCAL REG.: Mar. 8-50
REGISTRAR'S SIGNATURE: Carrie J. Linthicum
24. FUNERAL DIRECTOR: B.L. Hepping and Son ADDRESS: Annapolis, Md.

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RECEIVED
APR 4 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02320

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15-1

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Glen Burnie (Rural)
LENGTH OF STAY (in this place): 4 1/2 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 307 Orchard Road

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: A. A. Co
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Glen Burnie (Rural) GARLAND.
STREET ADDRESS (If rural, give location): 307 Orchard Road (Rural)

3. NAME OF DECEASED (Type or Print): (First) William (Middle) C. (Last) Becker

4. DATE OF DEATH: (Month) 3 (Day) 31 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 7/3/1874

9. AGE last birthday: 75 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Guard

10b. KIND OF BUSINESS OR INDUSTRY: Gas & Eled

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William G Becker

14. MOTHER'S MAIDEN NAME: Mary Bowers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 212-15-4696A

17. INFORMANT AND ADDRESS: Mr. Albert J. Becker (Brother)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Mitral Insufficiency	+2 months
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) General Arteriosclerosis	Unknown
447 / 92b	(c) Hypertension	+3 months

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/4/50, 19..... to 3/30/50, 19....., that I last saw the deceased alive on 3/30/50, 19....., and that death occurred at 3 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Ivestaor A. Boucher M.D. Glen Burnie, Md. 4/3/00

23. BURIAL, CREMATION REMOVAL (Specify): BURIAL

DATE THEREOF: APRIL 4, 1950

NAME OF CEMETERY OR CREMATORY: WESTERN

LOCATION (City, town, or county) (State): BALTIMORE MD

DATE REC'D BY LOCAL REG.: 4/4/50

REGISTRAR'S SIGNATURE: L. J. Dalla

24. FUNERAL DIRECTOR: Thomas W. Singleton

ADDRESS: GLEN BURNIE MD

602 V4

RECEIVED
APR 7 1950
BUREAU OF

02321

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH: COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 159 Hampton Ave. LENGTH OF STAY (in this place) 16 mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Linthicum, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE W. Va COUNTY Lewis
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Weston
STREET ADDRESS (If rural, give location) Route # 1

3. NAME OF DECEASED (Type or Print) (First) Thomas (Middle) Jackson (Last) Bishop
4. DATE OF DEATH (Month) Mar. (Day) 27 (Year) 1950
5. SEX M.
6. COLOR OR RACE W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH 12/30/63
9. AGE last birthday 86 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm owner
10b. KIND OF BUSINESS OR INDUSTRY Farmer
11. BIRTHPLACE (State or foreign country) Weston W. Va
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Joseph Bishop.
14. MOTHER'S MAIDEN NAME ~~Unknown~~ Sally Watson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cardio-Vascular Disease	1 yr.
422.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arterio-sclerosis	10 yr.
93d	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 12, 1949, to Mar 27, 1950, that I last saw the deceased alive on 3/27, 1950, and that death occurred at 11:40 A m., from the causes and on the date stated above.

SIGNATURE Chas. L. Ball Jr. (Degree or title) MD ADDRESS Linthicum, Md. DATE SIGNED 3/27/50

23. ~~BURIAL, CREMATION~~ REMOVAL (Specify)
DATE THEREOF 3-28-50
NAME OF CEMETERY ~~OR CREMATORY~~ Peterson
LOCATION (City, town, or county) (State) Weston W. Va.

DATE REC'D BY LOCAL REG. 3-29-50
REGISTRAR'S SIGNATURE Dr. Caldwell Woodruff
24. FUNERAL DIRECTOR James H. Lyons ADDRESS 4001 Fifty Highway Balto 25.

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 28 1950

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02322

CERTIFICATE OF DEATH

Reg. Dist. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Drury Md. — LENGTH OF STAY (in this place) 4 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Drury Md

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Baltimore Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore Md
STREET ADDRESS — (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Sarah (Middle) E (Last) Booze

4. DATE OF DEATH: (Month) March (Day) 7 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 1865 ?

9. AGE last birthday: 85 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (State or foreign country): Baltimore Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs Mary B Holt

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Hypostatic Pneumonia — Interval between onset and death:

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

520 X
97

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Generalized Arteriosclerosis, Decubiti, Malnutrition

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 25, 1950, to March 4, 1950, that I last saw the deceased alive on March 4, 1950, and that death occurred at 1:45 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Clayton R. Hines, M.D. — ADDRESS: Tolson Bldg, School St. Upper Marlboro Md. — DATE SIGNED: 3/7/50

23. BURIAL, CREMATION, REMOVAL (Specify): — DATE THEREOF: March 11 1950 — NAME OF CEMETERY OR CREMATORY: Mosser Cem. — LOCATION (City, town, or county): Drury — (State): Md.

DATE REC'D BY LOCAL REG.: March 10, 1950 — REGISTRAR'S SIGNATURE: P.M. Clayton Dep Clerk Reg

24. FUNERAL DIRECTOR: J. B. Johnson — ADDRESS: Annapolis

RECEIVED
MAR 13 1950
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02323

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH — COUNTY: A.A. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis — LENGTH OF STAY (in this place): 5 hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Anne Arundel General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md. — COUNTY: A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
STREET ADDRESS (If rural give location): 168 Green St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Charles	Carroll	Brice	March	14	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
M	W	M	5-5-1878	71 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer Ret.	Owner Farmer	A A Co Md	U.S.A.

13. FATHER'S NAME: George H. Bruce
14. MOTHER'S MAIDEN NAME: Ida Stinchcomb

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
		Mrs Mary T. Bruce Annapolis Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

151 K **Immediate cause** (a) Gastro Intestional Hemorrhage — 12 hrs.

46 b **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Gastric Carcinoma — 4 7 mos.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertensive C.V.D., Diabetes Mi- Aneurysm of Abd. Aorta

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
No				

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from Feb 10, 1950, to Mar 14, 1950, that I last saw the deceased alive on March 14, 1950, and that death occurred at 6:50 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Frank M. Shipley	M.D.	632 College Ave Annapolis	3/14/50

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	3-16-50	Cedar Bluff Cemt	Annapolis Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 16, 1950	[illegible]	John M. Taylor Son	Annapolis Md.

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RECEIVED
MAR 17 1950
BUREAU

02324

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: A. A. Co.

City or town: Pasadena P. O.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred: Heintzmans Grove

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: A. A.

City or town: Pasadena P. O.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Heintzmans Grove
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME: JULIUS F. BROWN

3. (b) Social Security Number: 218-09-

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband or~~ wife: Evelyn M. Brown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 3rd 1902

8. AGE: Years: 47 | Months: | Days: | If less than one day ..... hrs. ..... min.

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual occupation: Bar Tender

11. Industry or business: Roland Bruck - Sea Girt Inn

FATHER
12. Name: Julius Brown
13. Birthplace: Germany

MOTHER
14. Maiden name: Mary Narott
15. Birthplace: Germany

16. Informant: Evelyn M. Brown Heintzmans Grove Pasadena P. O.

Address: A. A. Co. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3/28/50 (month) (day) (year)

Cemetery or crematory: Holy Cross

Location: A. A. County Md.

18. Funeral director: Wilhoyt Cook Inc

Address: 217 N. Paul St

19. 3/28 1950 (Date rec'd by registrar) R. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 26 1950, at 8:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1947, to March 24 1956 and that I last saw h. 1 m alive on March 24 1956

	DURATION
Immediate cause of death: Coronary Thrombosis	3 days
Due to: Coronary Sclerosis	3 years
Due to: 420.1	
Other conditions: Degenerative Cardio-Vascular Disease (Include pregnancy within 3 months of death) 93d	3 years

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: J. Brady Smith M.D. (M.D. or other)

Address: Riviera Beach, Md. Date signed: 3/26/50

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02325

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY A. A. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS A. A. Co General

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural give location) Tudor Arms Apt. ✓

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Burwell (Last) Cheston

4. DATE OF DEATH: (Month) 3 (Day) 5 (Year) 1950

5. SEX: F

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)

8. DATE OF BIRTH: 7-9-1879

9. AGE last birthday: 70 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife none

10b. KIND OF BUSINESS OR INDUSTRY: None home

11. BIRTHPLACE (State or foreign country): A. A. Co. Md.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Elliott H. Burwell

14. MOTHER'S MAIDEN NAME: Augusta Sollers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Col. D. Murray Cheston. Annapolis Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

331X — **Immediate cause** (a) cerebral hemorrhage — 3 days

83a — **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) generalized arteriosclerosis

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 2nd 1950, to March 5th 1950, that I last saw the deceased alive on March 5th, 1950, and that death occurred at 3 10 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

Edith Roeller M.D. — 42 State Circle Annapolis md 3-6-50

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) | DATE THEREOF 3-7-50 | NAME OF CEMETERY OR CREMATORY Christ Church Yard | LOCATION (City, town, or county) West River (State) Md.

DATE REC'D BY LOCAL REG. March 7, 1950 | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR John M. Taylor — ADDRESS For Annapolis Md.

VS. A15

RECEIVED
MAR 8 1950
BUREAU V. S.

02326

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ODENTON
LENGTH OF STAY (in this place) 32 YEARS
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ANNE ARUNDEL
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ODENTON
STREET ADDRESS (If rural, give location) 5th STREET.

3. NAME OF DECEASED (Type or Print) (First) GEORGE (Middle) W. (Last) CLARK
4. DATE OF DEATH (Month) MARCH (Day) 1 (Year) 1950

5. SEX MALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWER
8. DATE OF BIRTH FEB 3, 1890
9. AGE last birthday 60 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER (Retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) WEST MOVELAND Co. PENNA.
12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME GEORGE W. CLARK
14. MOTHER'S MAIDEN NAME LIZZIE FARLOW

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY No. 223-72-2225
17. INFORMANT Mrs. EULA RAE FRANKS 5th STREET. ODENTON, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Occlusion	15 Min
420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d	(b) Hypertensive Cardio vascular disease	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct, 1947, to Mar 1, 1950 that I last saw the deceased alive on Feb 10, 1950, and that death occurred at 1205A m., from the causes and on the date stated above.

SIGNATURE Edward G Merritt SKERRITT (Degree or title) M.D. ADDRESS Gambrills DATE SIGNED 3-2-50

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL
DATE THEREOF MAR. 3
NAME OF CEMETERY OR CREMATORY CHURCH OF GOD
LOCATION (City, town, or county) GAMBRILLS (State) MD

DATE REC'D BY LOCAL REG. 3/3/50
REGISTRAR'S SIGNATURE L. J. DeAlba
24. FUNERAL DIRECTOR Thomas W Singleton ADDRESS Glen Burnie, Md

30809

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 8 1990
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

02327

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN P.O. Arnold. | LENGTH OF STAY (In this place) 6 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Maya Vista

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lanne
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
John	Leonard	Colburn.	March.	22	1950

5. SEX	6. COLOR OR RACE	7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~ (Specify)	8. DATE OF BIRTH	9. AGE Last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	married	10/24/1904	45 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Fireman	Electric Railroad	Annapolis, Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Harry Colburn.	Jennie Golden.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No	215-09-4658.	Mrs. J.R. Colburn (wife)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Occlusion	Sudden.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

420.1 9-1a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
	—	—		

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
— m.		—

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Conrad A. Raubenheimer M.D.	Assistant Medical Examiner	Annapolis - Glen Burnie Rd.	3/27/50

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
	3-25-1950	Cedar Bluff	Annapolis	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 25, 1950	Mrs. O. Brasch	John M. Taylor & Son	Annapolis, Md.

45649

RECEIVED
MAR 29 1950
BUREAU V. S.

02328

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH · COUNTY A.A. MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Md. COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural-Manhattan Beach; LENGTH OF STAY (in this place) 21 yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural-Severna Park Md.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Home	STREET ADDRESS (If rural give location) —

3. NAME OF DECEASED (Type or Print) (First) David James (Middle) (Last) Connolly				4. DATE OF DEATH (Month) 3 (Day) 14 (Year) 1950			
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH Feb 12, 1887	9. AGE last birthday 63 yrs.	If under 1 year Months / Days	If under 24 hrs. Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building.	11. BIRTHPLACE (State or foreign country) New York.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME David J. Connolly			14. MOTHER'S MAIDEN NAME unknown (Sheen?)				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WORLD #1		16. SOCIAL SECURITY No.	17. INFORMANT Daughter - Miss Mary R. Connolly				

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
151x Immediate cause	(a) Carcinomatosis	2+ mon
46b Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Gastric Carcinoma	—
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION —	19b. MAJOR FINDINGS OF OPERATION —	20. AUTOPSY? Yes ☐ No ☑
21. ACCIDENT SUICIDE HOMICIDE (Specify) —	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	(CITY OR TOWN) — (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 2/25/, 1950, to 3/14, 1950, that I last saw the deceased alive on 3/14/, 1950, and that death occurred at 130 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Frank M. Shipley	MD.	63 College Ave, Annapolis	3/14/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 3/17/50	NAME OF CEMETERY OR CREMATORY Baltimore National	LOCATION (City, town, or county) (State) Baltimore Md.
DATE REC'D BY LOCAL REG. 3-15-50	REGISTRAR'S SIGNATURE E. W. Hedrick	24. FUNERAL DIRECTOR C. Vernon Lemmon	ADDRESS 4611 Park Hgts Ave Baltimore Md.

308V9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

02329

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH · COUNTY A. A. MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Md. COUNTY A. A. Co
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brooklyn — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brooklyn
HOSPITAL OR INSTITUTION OR STREET ADDRESS 6407 Ritchie Highway	STREET ADDRESS (If rural, give location) 6407 Ritchie Highway

3. NAME OF DECEASED (Type or Print)	(First) Sedwick	(Middle) T	(Last) Cromwell	4. DATE OF DEATH	(Month) March	(Day) 10	(Year) 1950
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH Mar. 3, 1862	9. AGE last birthday 88 yrs.	If under 1 year Months	Days	If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer rtd Owner	10b. KIND OF BUSINESS OR INDUSTRY farming	11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME John G. Cromwell	14. MOTHER'S MAIDEN NAME Amanda E. Harmons						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If year, give war or dates of service)	16. SOCIAL SECURITY NO. —	17. INFORMANT AND ADDRESS Mr. R. Chester Cromwell 6407 Ritchie Hgwy					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cebral Hemorrhage	3 weeks
331X Antecedent cause(s)		
83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arterio Sclerosis	3 yrs.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —	19b. MAJOR FINDINGS OF OPERATION —	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify) —	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	(CITY OR TOWN) — (COUNTY) — (STATE) —
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Jan, 1940, to March 10, 1950, that I last saw the deceased alive on March 9, 1950, and that death occurred at 6 A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
James S. Bellingham M.D.		Glen Burnie Md	March 10, 1950.

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 3/13/50	NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.	LOCATION (City, town, or county) A. A. Co. (State) Md.
DATE REC'D BY LOCAL REG. 3/11/50	REGISTRAR'S SIGNATURE H.W. Hedrick	24. FUNERAL DIRECTOR WM. J. TICKNER & SONS	ADDRESS Balto., Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH

02330

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 1133

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Glen Burnie
LENGTH OF STAY (in this place): 5 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 411 Old Annapolis Blvd

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Glen Burnie
STREET ADDRESS (If rural, give location): 411 Old Annapolis Blvd

3. NAME OF DECEASED (Type or Print): (First) John (Middle) C. (Last) Crump

4. DATE OF DEATH: (Month) March (Day) 16 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Nov. 10, 1909

9. AGE last birthday: 40 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ship Rigger

10b. KIND OF BUSINESS OR INDUSTRY: Bethlehem Key Highway

11. BIRTHPLACE (State or foreign country): Chicago Ill.

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Alfred Crump

14. MOTHER'S MAIDEN NAME: Jane Stenning

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 210-10-3643

17. INFORMANT: Mrs. John C. Crump 411 old Annapolis Blvd. Glen Burnie

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: No. Sudden

420.1 94a

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY —

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: noturol causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: Gustave A. Rauber M.D. (Degree or title): acting deputy medical examiner ADDRESS: Glen Burnie, Md. DATE SIGNED: 3/16/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: Mch. 20, 1950 — NAME OF CEMETERY OR CREMATORY: Glen Haven — LOCATION (City, town, or county): Glen Burnie (State): Md.

DATE REC'D BY LOCAL REG. 3/17/50 — REGISTRAR'S SIGNATURE: L. J. De Alba

24. FUNERAL DIRECTOR: Thomas D. Pierpaw ADDRESS: Glen Burnie Md.

496 40

RECEIVED
MAR 20 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02331

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Wild Rose Shore
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Near Annapolis
STREET ADDRESS (If rural give location) N. Wild Rose Shore

3. NAME OF DECEASED (Type or Print): (First) Sara (Middle) Hay Covode (Last) Davis

4. DATE OF DEATH: (Month) 3 (Day) 10 (Year) 1950

5. SEX: 7

6. COLOR OR RACE: W.

7. ~~SINGLE, MARRIED,~~ WIDOWED, ~~DIVORCED,~~ (Specify)

8. DATE OF BIRTH: 3-1-1862

9. AGE last birthday: 88 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Pleasant Unity Pa.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: George Hay Covode

14. MOTHER'S MAIDEN NAME: Bettie St Clair Robb

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs Chas L. Davis Annapolis Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Acute Coronary Thrombosis	12 hrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arterial Hypertension	Several
420.1 94a	(c) + Arteriosclerosis	years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan., 19 49., to 10 March, 19 50., that I last saw the deceased alive on 10 March, 19 50., and that death occurred at 7.05 P. m., from the causes and on the date stated above.

SIGNATURE J. Oliver Pereis (Degree or title) M.D. ADDRESS Annapolis Md DATE SIGNED Mch 11/50

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF 3-13-50 | NAME OF CEMETERY OR CREMATORY Glenwood | LOCATION (City, town, or county) Washington (State) D C.

DATE REC'D BY LOCAL REG. March 13, 1950 | REGISTRAR'S SIGNATURE [illegible] | 24. FUNERAL DIRECTOR John M. Taylor Son ADDRESS Annapolis Md.

RECEIVED
MAR 14 1950
BUREAU V. S.

02332

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH · COUNTY: Anne Arundel — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville — LENGTH OF STAY (in this place):	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rockville
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital	STREET ADDRESS (If rural, give location): Cohnty Home

3. NAME OF DECEASED (Type or Print)	(First) Lizzie	(Middle)	(Last) Dimes	4. DATE OF DEATH (Month) 3/28/50 (Day) (Year) 19
5. SEX: female	6. COLOR OR RACE: colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single	8. DATE OF BIRTH: not known approx.	9. AGE last birthday: not known yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): not known	10b. KIND OF BUSINESS OR INDUSTRY: none	11. BIRTHPLACE (State or foreign country): not known	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: not known		14. MOTHER'S MAIDEN NAME: not known		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS: Patient came from County Home who gave no information.		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	known since 2/27/50
331x Antecedent cause(s)		
83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c) Mental Deficiency without Psychosis	known since 7/2/48

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none	19b. MAJOR FINDINGS OF OPERATION: none	20. AUTOPSY? Yes X No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify): none	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none	(CITY OR TOWN) (COUNTY) (STATE): none
TIME OF INJURY (Month) (Day) (Year) (Hour): none m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from 7/2/48, 19....., to 3/28/50, 19....., that I last saw the deceased alive on 3/28/50, 19....., and that death occurred at 7:45 A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Jacob Marguerite M.D.		Crownsville, Md.	3/28/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE: 4/4.50	NAME OF CEMETERY OR CREMATORY: Hospital	LOCATION (City, town, or county) (State): Crownsville Md
DATE REC'D BY LOCAL REG.: 4/4-50	REGISTRAR'S SIGNATURE: E. F. Joyce L. Reg	24. FUNERAL DIRECTOR: Supt Hospital	ADDRESS: Crownsville Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 6 1950
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02333

CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel, Jessups STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS MHC Jessups, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural give location) 412-W. Fayette St. Balto., Md.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
John	Millholland	Donaldson	March	24	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
Male	White	Single	Feb. 4, 1887	63 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Porter
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Henry G. Donaldson
14. MOTHER'S MAIDEN NAME: Elizaberth Kelly

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): unknown
(If year, give war or dates of service)
16. SOCIAL SECURITY NO.: unknown
17. INFORMANT: Mary Hanora Donaldson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Exhaustion	One Wk.
450.0 Antecedent cause(s)		
97 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Malnutrition	Many Months
	(c) Arterio-sclerosis Chronic	Years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Enlarged Prostate, with incontinence of urine Chronic

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Feb. 23, 1950, to March 24, 1950, that I last saw the deceased alive on Mar. 24, 1950, and that death occurred at 12:30 m., from the causes and on the date stated above.

SIGNATURE: John A. Clark (Degree or title) ADDRESS DATE SIGNED
John A. Clark M.D., Physician in Charge, MHC Jessups, Maryland 3/24/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	3/27/50	New Cathedral Cem.	Baltimore, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 25th 1950	R.W.	Chas. E. Evans & Son	118 Wt. Mt. Royal Ave.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02334

CERTIFICATE OF DEATH

Reg. Dist. No. 2

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH · COUNTY: Anne Arundel Co. · STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Waterbury
LENGTH OF STAY (in this place): 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Railroad Ave

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland · COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Waterbury
STREET ADDRESS (If rural give location): Railroad Ave

3. NAME OF DECEASED (Type or Print): (First) Ida (Middle) M. (Last) Emmons

4. DATE OF DEATH: (Month) 3 (Day) 13 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: 12/1/1879

9. AGE last birthday: 70 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: at Home

11. BIRTHPLACE (State or foreign country): Fawneytown Md.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: James Culbertson

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Mr Clarence S. Emmons 1244 Wash. Blvd.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443K **Immediate cause** (a) Cerebral Hemorrhage. — Interval between onset and death: 2 days.

Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertensive Cardio-Vascular disease — 8 years

(c) Generalized Arterio-sclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct, 1946, to Mar 13, 1950, that I last saw the deceased alive on Mar 13, 1950, and that death occurred at 5:43 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Edward P Hewitt	M.D.	Cambrills	3-13-50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	3/16/50	London Park Cem.	3801 Frederick Ave

DATE RECD BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
3/14/50	H W. Hedrick	John J. Cowan & Son	90 Hollins St.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02335

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS A.A. Co. General Hospt

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY A. A. Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport
STREET ADDRESS (If rural give location) 1031 Bancker Ave.

3. NAME OF DECEASED (Type or Print) (First) Charles (Middle) H. (Last) Ford

4. DATE OF DEATH (Month) 3 (Day) 15 (Year) 1950

5. SEX Male | 6. COLOR OR RACE White | 7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify) | 8. DATE OF BIRTH 1-22-1887 | 9. AGE last birthday 63 yrs. | If under 1 year Months Days | If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Worker | 10b. KIND OF BUSINESS OR INDUSTRY Boats Gnd | 11. BIRTHPLACE (State or foreign country) Eastport Md. | 12. CITIZEN OF WHAT COUNTRY U.S.A.

13. FATHER'S NAME Charles H. Ford

14. MOTHER'S MAIDEN NAME Mary E. Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 214-05-0413

17. INFORMANT Pearl R. Ford

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute Dilatation of Heart	Sudden
331 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Oedema of Lungs	10 Days
83a	(c) (general) arterio-sclerosis	2 years or more

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Left Sided Cerebral Hemorrhage 7 weeks ago

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 25, 1950, to March 15 1950, that I last saw the deceased alive on Mar. 15, 1950, and that death occurred at 2:10 P. m., from the causes and on the date stated above.

SIGNATURE John M. Claffy (Degree or title) M.D. ADDRESS 98 Glenarden St Annapolis Md DATE SIGNED 3/18/50

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify) | DATE THEREOF 3-18-50 | NAME OF CEMETERY OR CREMATORY Cedar Bluff | LOCATION (City, town, or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REG. March 18, 1950 | REGISTRAR'S SIGNATURE [illegible] | 24. FUNERAL DIRECTOR John M. Taylor Son ADDRESS Annapolis Md.

49648

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 22 1950
BUREAU V. S.

02336

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH COUNTY: Ca — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Fair Haven
LENGTH OF STAY (in this place): 1
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED STATE: DC — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Washington
STREET ADDRESS (If rural, give location): 2232 Mt View Place S.E.

3. NAME OF DECEASED (Type or Print): (First) George (Middle) Emerson (Last) Frazier
4. DATE OF DEATH: (Month) 3 (Day) 12 (Year) 1950

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M
8. DATE OF BIRTH: 10/1/1894
9. AGE last birthday: 55 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Business truck driver
10b. KIND OF BUSINESS OR INDUSTRY: Coal & Fuel Oil Dealer
11. BIRTHPLACE (State or foreign country): DC
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel F B Frazier
14. MOTHER'S MAIDEN NAME: Frances Dalton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If year, give war or dates of service): World War I
16. SOCIAL SECURITY No.:
17. INFORMANT AND ADDRESS: Mrs. Geo. E Frazier

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary embolism — 30 min

420.1 Antecedent cause(s)

94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) —

(c) —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Had had previous attacks — July 18, 1949

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify):
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 18, 1949, to March 12, 1950, that I last saw the deceased alive on March 12, 1950, and that death occurred at 8 A m., from the causes and on the date stated above.

SIGNATURE: H M Ward (Degree or title) — ADDRESS: Owing Md. — DATE SIGNED:

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE: 3-15-50
NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
LOCATION (City, town, or county) (State): Suitland Maryland

DATE REC'D BY LOCAL REG.: Mar 13th 1950
REGISTRAR'S SIGNATURE: M. R. Clayton Dep Reg
24. FUNERAL DIRECTOR: Simmons Bros. — ADDRESS: 2007 Nichols ave S.E.

27277

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

M. W. R Clayton Registrar
Mt Zion Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02337

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:

County Annarundel Co

City or town Glenburnie
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred: .....

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Annarundel

City or town .....
(If outside city or town limits, write RURAL and give nearest town)

Street No. Ritchie Highway
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME: Emley Jane Furness

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: David Furness

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 25th 1868

8. AGE: Years 81 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: Md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: —

FATHER
12. Name: John Simpson
13. Birthplace: Md

MOTHER
14. Maiden name: —
15. Birthplace: —

16. Informant: Mr David Furness

Address

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof: Mar 16th 1950
(month) (day) (year)

Cemetery or crematory: Balto Cem

Location: E. North Ave Ext

18. Funeral director: Leo S. Cook

Address: 1703 N Patterson Park Ave

19. 3-16 1950 (Date rec'd by registrar) A. W. Hedrick wh Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 12 1950 at 4:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1950 to March 12 1950 and that I last saw her alive on March 10 1950

Immediate cause of death: Cerebral Infarct

Due to .....

Due to .....

Other conditions: Uremia. Cardio Renal Disease
(Include pregnancy within 3 months of death)

DURATION: 3 days p. / 1 week. / —

332 A
Major findings of operations .....
131a Date of op .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Joseph Lipskey M.D. or other

Address: Aleutor Md Date signed March 14-50

MARYLAND STATE DEPARTMENT OF HEALTH

02338

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: a. a. Co. MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md COUNTY: a.a.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Riviera Brach; LENGTH OF STAY (in this place):	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Riviera Brach
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Main Ave	STREET ADDRESS (If rural, give location): Main Ave

3. NAME OF DECEASED (Type or Print): (First) Charles (Middle) P. (Last) Gehrman			4. DATE OF DEATH: (Month) Mar (Day) 13th (Year) 1950	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 4/7/1891	9. AGE last birthday: 58 yrs. — If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sail Maker	10b. KIND OF BUSINESS OR INDUSTRY: U.S. Coast Guard	11. BIRTHPLACE (State or foreign country): Balto. Md.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Albert Gehrman		14. MOTHER'S MAIDEN NAME: Natalie Miller		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No	(If year, give war or dates of service):	16. SOCIAL SECURITY NO.:	17. INFORMANT AND ADDRESS: Mina M. Gehrman Riviera Brach Main Ave.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
18 1/2	Immediate cause	(a) Heart Failure	2 days
52 b	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinoma Bladder	2 years
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from June, 1942, to March 13, 1950, that I last saw the deceased alive on March 12, 1950, and that death occurred at 8:10 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
G. Brady Smith	M.D.	Riviera Beach, Md.	3/13/50

23. BURIAL, CREMATION / REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	3/16/50	London Park	Balto. Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
3/14/50	H.W. Hedrick	Wm Cook Inc	1217 St. Paul St

VS. A15

34446

Gehermann

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02339

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH
COUNTY Anne Arundel Co MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linthicum Heights
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE COUNTY
313 N Camp Meade Rd A.A. Co
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linthicum Heights
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Lawrence	Neal	Gibson	3	2	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
M	W	Widower	July 29 1879	70 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter - forms for Concrete	City Balto	Calvert Co Md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Gibson	Jennie George

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
	none	Lawrence E. Gibson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

157 X Immediate cause (a) Carcinoma of pancreas — Interval Between Onset and Death: 6 months

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
46 g (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Jan 15, 1950, to March 3, 1950, that I last saw the deceased alive on Feb 21, 1950, and that death occurred at 145 a. m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
P. J. Ormaldi M.D.	4609 Gov. Ritchie Hwy	3-2-50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	3/6/1950	Loudon Park Cem	Fredrick Rd

DATE RECD BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
3/3/50	K.W. Hefner	Chas P. Towell	2427 Edmondson Ave

30498

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

02340

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (in this place) 8 mos. 6 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Balt, city
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 653 Dover Street

3. NAME OF DECEASED (Type or Print): (First) Florence (Middle) (Last) Goburn

4. DATE OF DEATH: (Month) 3/16/50 (Day) (Year) 19

5. SEX: female

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed

8. DATE OF BIRTH: about 1885 ~~not known~~

9. AGE last birthday: 64 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Esriel Bradey

14. MOTHER'S MAIDEN NAME: not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): ~~~~~

16. SOCIAL SECURITY NO.: ~~~~~

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage — known since 3/9/50

Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) General Arteriosclerosis — known since 6/10/49

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

33 I X
83a

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION: none

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): none

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY: none

(CITY OR TOWN): none (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): none m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from 6/10/49, 19....., to 3/16/50, 19....., that I last saw the deceased alive on 3/16/50, 19....., and that death occurred at 10:11 A m., from the causes and on the date stated above.

SIGNATURE: Jacob Marguette (Degree or title) M.D. ADDRESS: Crownsville, Md. DATE SIGNED: 3/16/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 3/21/50 — NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem. — LOCATION (City, town, or county) (State): Brooklyn A.G. Co. Md

DATE REC'D BY LOCAL REG. 3/20/50 — REGISTRAR'S SIGNATURE: A. W. Hodges

24. FUNERAL DIRECTOR: Elroy O. Wilson — ADDRESS: 1000 Guilford Ave

02341

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH· COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED· STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Marley — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Marley
HOSPITAL OR INSTITUTION OR STREET ADDRESS 7 Second Ave.	STREET ADDRESS (If rural give location) 7 Second Ave

3. NAME OF DECEASED (Type or Print) (First) FRANCIS (Middle) JAMES (Last) GOFF

4. DATE OF DEATH (Month) March (Day) 6 (Year) 1950

5. SEX M — 6. COLOR OR RACE W — 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) — 8. DATE OF BIRTH May 11, 1888 — 9. AGE last birthday 61 yrs. — If under 1 year Months Days — If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter - Building Painter — 10b. KIND OF BUSINESS OR INDUSTRY — 11. BIRTHPLACE (State or foreign country) Providence Rhode Island — 12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME Frank J. Goff. — 14. MOTHER'S MAIDEN NAME Rose McCaughey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) — 16. SOCIAL SECURITY No. 200-03-2155 — 17. INFORMANT Matthew Goff (brother)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Arteriosclerotic Cardio-Vascular Disease — years.

422.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis general.

93d (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Bronchitis sever.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/25, 1950, to 3/6, 1950, that I last saw the deceased alive on 2/25, 1950, and that death occurred at 12:30 P.m., from the causes and on the date stated above.

SIGNATURE Bobby L. Jones (Degree or title) M.D. ADDRESS 5 Central Ave S.W. Glen Burnie DATE SIGNED 3/6/50

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL — DATE THEREOF 3-8-50 — NAME OF CEMETERY OR CREMATORY GLEN HAVEN — LOCATION (City, town, or county) GLEN BURNIE, (State) MD

DATE REC'D BY LOCAL REG. ~~Burial~~ 3/7 — REGISTRAR'S SIGNATURE [signature] — 24. FUNERAL DIRECTOR Thomas D. Singleton — ADDRESS Glen Burnie, Md

34049

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 9 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

02342

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH: COUNTY: Anne Arundel; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville; LENGTH OF STAY (in this place): 5 mos. 6 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: U.S. Born; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Turners; STREET ADDRESS (If rural, give location): 302 Wheeler Court

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) (Last) Green

4. DATE OF DEATH: (Month) 3/6/50 (Day) (Year) 19

5. SEX: female

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): separated

8. DATE OF BIRTH: March 5, 1894

9. AGE last birthday: 56 xxx yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: ~~none~~ home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Joseph Butler

14. MOTHER'S MAIDEN NAME: Emma Queen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): xxxxxxxx

16. SOCIAL SECURITY No.: xxxxxxxx

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443 92d

Immediate cause (a) Hypertensive cardiovascular disease

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH: Known to us since adm. 9/29/49

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: xxxxxxxx

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) xxxxxxxx; PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: xxxxx (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): xxxxxx m.; INJURY OCCURRED While at Work ☐ Not While At work ☐; HOW DID INJURY OCCUR? xxxxxxxx

22. I hereby certify that I attended the deceased from 9/29/49, 19....., to 3/6/50, 19....., that I last saw the deceased alive on 3/6/50, 19....., and that death occurred at 9:22 Am m., from the causes and on the date stated above.

SIGNATURE: Jacob Marquisten (Degree or title) M.D. ADDRESS: Crownsville, Md. DATE SIGNED: 3/6/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial; DATE: 3/9/00; NAME OF CEMETERY OR CREMATORY: St Peters; LOCATION (City, town, or county) (State): Balto md

DATE REC'D BY LOCAL REG. 3/7/50; REGISTRAR'S SIGNATURE: A. W. Hedgecock

24. FUNERAL DIRECTOR: Geo. B. Kelson; ADDRESS: 1303 Pennsylvania Ave

02343

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH · COUNTY A.A. MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Md COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ~~Galesville~~ Annapolis — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS A.A. Co General Hospital	STREET ADDRESS (If rural give location) Annapolis Md.

3. NAME OF DECEASED (Type or Print) (First) George (Middle) (Last) Hebron			4. DATE OF DEATH (Month) Mar (Day) 4 (Year) 1950		
5. SEX m	6. COLOR OR RACE col.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH about 1861	9. AGE last birthday 68 yrs.	If under 1 year Months / Days; If under 24 hrs. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY Oysterman		11. BIRTHPLACE (State or foreign country) Md	12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Brown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY No.		17. INFORMANT Harrison Brent		

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
443X Immediate cause	(a) arteriosclerotic cardiovascular	
93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) disease & hypertension	10-20 yrs.
	(c)	

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/1, 1950, to 3/4, 1950, that I last saw the deceased alive on 3/4, 1950, and that death occurred at 1:20 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
S. Bonnich	M.D	Annapolis Md	3/4/50

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) Burial	DATE THEREOF Mar 7. 1950	NAME OF CEMETERY ~~OR CREMATORY~~ Dan'l Star Conn	LOCATION (City, town, or county) (State) West River Maryland
DATE REC'D BY LOCAL REG. March 6, 1950	REGISTRAR'S SIGNATURE [signature]	24. FUNERAL DIRECTOR F. A. Hardesty & Son	ADDRESS Galesville Md

70071

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 7 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

02344

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel County General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY A. A.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; STREET ADDRESS (If rural give location) 100 Smithville

3. NAME OF DECEASED (Type or Print): (First) Donald (Middle) (Last) Henderson

4. DATE OF DEATH: (Month) 3 (Day) 7 (Year) 1950

5. SEX: M

6. COLOR OR RACE: C

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 11/12/15

9. AGE last birthday: 34 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Build homes

11. BIRTHPLACE (State or foreign country): La

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Albert Henderson

14. MOTHER'S MAIDEN NAME: Bertha Theabaux

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Charlotte Henderson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

231 Immediate cause (a) Hemorrhage into rt. Cerebellum — Interval Between Onset and Death: 2 wks?

83a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT ~~SUICIDE~~ ~~HOMICIDE~~ (Specify) None known | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/7/, 1950, to 3/7/, 1950, that I last saw the deceased alive on 3/7/, 1950, and that death occurred at 4P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Frank M. Shipley	M.D.	63 College Ave, Annapolis	3/9/50

23. ~~BURIAL~~, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, Town, or County)	(State)
	Mar. 10, 1950	Congregational	Abbeville	La.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 10, 1950	[signature]	J. B. Johnson	Annapolis

308 V9

VS. A15

RECEIVED
MAR 13 1950
BUREAU V. S.

02345

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severna Park. LENGTH OF STAY (in this place) 2 1/2 mnts.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Old Annapolis Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland. COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severna Park.
STREET ADDRESS (If rural, give location) Old Annapolis Rd.

3. NAME OF DECEASED (Type or Print) (First) Clarence (Middle) (Last) Hicks
4. DATE OF DEATH (Month) March (Day) 2 (Year) 1950
5. SEX Male
6. COLOR OR RACE Colored.
7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~ (Specify) Married
8. DATE OF BIRTH 1/6/1907
9. AGE last birthday 43 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Automobile Mechanic
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Thomas Hicks
14. MOTHER'S MAIDEN NAME Betty ?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. 214-14-0197
17. INFORMANT Mrs. Noreen Hicks (step-mother)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause	(a) Coronary Occlusion	2 hrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 94a	(b) Paralysis of right leg - result	
	(c) of Infantile paralysis at age of 2 yrs.	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE Gustave H. Fauberdin (Degree or title) assistant medical examiner. ADDRESS Glen Burnie, Md. DATE SIGNED 3/2/50.

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 3/5/50
NAME OF CEMETERY OR CREMATORY Early Height Baptist Cemetery
LOCATION (City, town, or county) Anne Arundel County (State) Md
DATE REC'D BY LOCAL REG. 3/3/50
REGISTRAR'S SIGNATURE Eric Hedrick
24. FUNERAL DIRECTOR Joseph A. Lively 661 W. Barre St
ADDRESS Baltimore Md

33284

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

02346

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Shady Side
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Shady Side
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) Elizabeth M. (Last) Holland
4. DATE OF DEATH (Month) March (Day) 10 (Year) 1950

5. SEX Fem.
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widow
8. DATE OF BIRTH Oct. 8 1872
9. AGE last birthday 77 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic
10b. KIND OF BUSINESS OR INDUSTRY Genl. Housecwfe
11. BIRTHPLACE (State or foreign country) A. A. Co.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Crowner
14. MOTHER'S MAIDEN NAME Rachiel Crowner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS Minnie Washington, Shady Side, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
491X	Immediate cause (a)	Acute Myocarditis	3 days
93e	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	Acute Bronchio-Pneumonia	7 days
	(c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 4, 1950, to March 10, 1950, that I last saw the deceased alive on March 10, 1950, and that death occurred at 5:45 P m., from the causes and on the date stated above.

SIGNATURE R. L. Richardson (Degree or title) MD ADDRESS Annapolis, Md. DATE SIGNED 3/14/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF March 14, 1950
NAME OF CEMETERY OR CREMATORY St. Matthews
LOCATION (City, town, or county) Shady Side, (State) Md.

DATE REC'D BY LOCAL REG. March 14, 1950
REGISTRAR'S SIGNATURE I. B. Dent Mar 16
24. FUNERAL DIRECTOR J B Johnson ADDRESS Annapolis, Md.

52086

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 17 1960
U. S. GEOLOGICAL SURVEY

NAME OF DECEASED CHANGED TO GEORGE thru Baltimore marriage license of 3-30-32 (wife ELSIE KENT) and thru funeral director's affidavit, filmed G124 3-7-50. LL

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02347

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Balt.city
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville — LENGTH OF STAY (in this place) 1 yr. 5 mos.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital	STREET ADDRESS (If rural, give location) not known ✓

3. NAME OF DECEASED (Type or Print) (First) ~~Eddie~~ (Middle) GEORGE (Last) Jackson			4. DATE OF DEATH (Month) 3/3/50 (Day) (Year) 19	
5. SEX male	6. COLOR OR RACE colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH 1875	9. AGE last birthday 75 (over) yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer ✓	10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME James Jackson			14. MOTHER'S MAIDEN NAME Caroline Lucas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS Hospital Records	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Chronic Myocarditis	known since 10/19/48
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) General Paresis	
	(c)	

025 x
30 b

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION none	19b. MAJOR FINDINGS OF OPERATION none	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify) none	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	(CITY OR TOWN) none (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) none m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/19/48, 19....., to 3/3/50, 19....., that I last saw the deceased alive on 3/3/50, 19....., and that death occurred at 1:25 P.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Jacob Morgenstern M.D.		Crownsville, Md.	3/6/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE 3-10-50	NAME OF CEMETERY OR CREMATORY Mt Auburn cemtry	LOCATION (City, town, or county) Balto (State) Md.
DATE REC'D BY LOCAL REG. 3-7-50	REGISTRAR'S SIGNATURE L	24. FUNERAL DIRECTOR Walter B. Spring Jr.	ADDRESS 1390 W Hamburg St.

LL wrote for age date & name

3/7 1950 L

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

According to the certified copy of the marriage license of the deceased submitted by Elsie Jackson, his wife, the age of the deceased is 57 years. 3/10/50 js

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

02348

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis | LENGTH OF STAY (in this place): 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Anne Arundel General

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Severn — Rural
STREET ADDRESS (If rural give location): Crain Highway

3. NAME OF DECEASED (Type or Print): (First) Charles (Middle) A. (Last) Johnson Jr.

4. DATE OF DEATH: (Month) March (Day) 9 (Year) 19 50

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widower

8. DATE OF BIRTH: Oct. 24, 1883

9. AGE last birthday: 66 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Mln.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): R.R. Condr. Retired

10b. KIND OF BUSINESS OR INDUSTRY: B&O R R

11. BIRTHPLACE (State or foreign country): Frederick, Md.

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Charles A. Johnson, Sr.

14. MOTHER'S MAIDEN NAME: -------- Howard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 705-09-6719

17. INFORMANT: Wm. A. Johnson, 925 Jeffery St. Brooklyn, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) arteriosclerotic cardiovascular disease — | Interval between onset and death: 2

422.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) —

93d (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. bronchial asthma

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

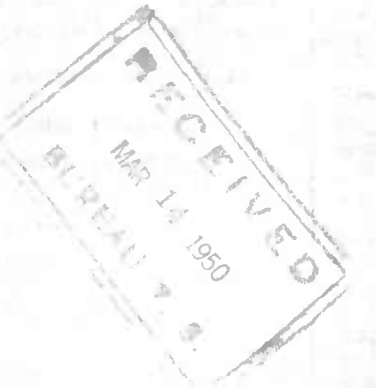
22. I hereby certify that I attended the deceased from 3/7, 19 50, to 3/9, 19 50, that I last saw the deceased alive on 3/8, 19 50, and that death occurred at 3:00 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED
T. Bowers M.D. | Annapolis Md | 3/9/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: Mch. 11, 1950 | NAME OF CEMETERY OR CREMATORY: Loudon Park | LOCATION (City, town, or county) (State): Baltimore, Md.

DATE REC'D BY LOCAL REG. 3/10/50 | REGISTRAR'S SIGNATURE: Wm. Franke | 24. FUNERAL DIRECTOR: Thomas W. Singleton, ADDRESS: Glen Burnie, Md.

25498


RECEIVED
MAR 14 1950

MARYLAND STATE DEPARTMENT OF HEALTH

02349

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 11 Acton Place

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A A
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural give location) 11 Acton Place

3. NAME OF DECEASED (Type or Print): (First) Mary Carter (Middle) Craven (Last) Johnson

4. DATE OF DEATH: (Month) 3 (Day) 21 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~. (Specify) W

8. DATE OF BIRTH: July 4-1874

9. AGE last birthday: 75 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: House wife

11. BIRTHPLACE (State or foreign country): Phila Pa

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Robert Craven

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Capt. Theo W. Johnson U.S.N. Ret. Annapolis Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Generalized carcinomatosis	2-3 yrs.
170 X Antecedent cause(s) 50 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinoma of breast	2-3 yrs.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Radical Breast operation, Amputation of rt. thigh.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION: Carcinoma; Metastasis to bone, lung, etc

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 3, 1950, to Mar 21, 1950, that I last saw the deceased alive on 3/21, 1950, and that death occurred at 450 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Maurice K Myers, MD ADDRESS Annapolis, Md DATE SIGNED 3/22/50

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify) DATE THEREOF 3-23-50 NAME OF CEMETERY OR CREMATORY Naval Academy LOCATION (City, town, or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REG. March 23, 1950 REGISTRAR'S SIGNATURE M. E. Branch

24. FUNERAL DIRECTOR John W. Taylor Son ADDRESS Annapolis Md.

RECEIVED
MAR 24 1950
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02350

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Best Gate
MARYLAND
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Best Gate
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) Jeremiah (Middle) (Last) Jones

4. DATE OF DEATH: (Month) March (Day) 10 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow

8. DATE OF BIRTH: March 31, 1872

9. AGE last birthday: 77 yrs. If under 1 year: Months 11 Days 17 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Md. A.A. Co.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Rosin Jones

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: James Jones

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 **Immediate cause** (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

94a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: (CITY OR TOWN) Annapolis (COUNTY) A A (STATE) Md

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-6, 1950, to 3-10, 1950, that I last saw the deceased alive on 3-8, 1950, and that death occurred at 11:00 A m., from the causes and on the date stated above.

SIGNATURE: F. I. Allen (Degree or title): M D ADDRESS: 10 Carroll DATE SIGNED: 3-14-50

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify): | DATE THEREOF: March 14, 1950 | NAME OF CEMETERY OR CREMATORY: Fowlers | LOCATION (City, town, or county) (State): Best Gate, Md.

DATE REC'D BY LOCAL REG.: March 14, 1950

REGISTRAR'S SIGNATURE: J. [illegible]

24. FUNERAL DIRECTOR: Annie A. Johnson ADDRESS: Annapolis, Md.

RECEIVED
MAR 17 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02351

CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Anne Arundel — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville — LENGTH OF STAY (in this place): 3 weeks	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore City
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital	STREET ADDRESS (If rural, give location): 327 N. Bruce St.,

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	John	R.	Kellum		3	7	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
Male	Negro	widower	Dec. 18 1875	74 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Foreman	Revere Copper Works	Unknown	?

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George Kellum	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
		Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a)	Chronic myocarditis	Known to us since adm.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	Pneumonia	-12 days 2/17/50
(c)		

422.2
93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/17, 1950, to 3/7, 1950, that I last saw the deceased alive on 3/7, 1950, and that death occurred at 5:10a m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Jacob Brunquist M.D		Crownsville, Maryland	3/7/50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	3/11/50	Arbutus Mem'l. Pk	Balto. County, Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
3/9/50	A. W. Hedrick	Chas. G. Cooper	512 Carrollton Av

VS-A15

3163

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02352

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pasedena (Rural) | LENGTH OF STAY (in this place) 10 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pasedena
STREET ADDRESS (If rural, give location) Old Annapolis Road

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
GEORGE	JOSEPH	HESS KIDWELL	March	30	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
M	W	Div.	March 11, 1911	39 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
AUTO MECHANIC		Maryland	USA.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James Thomas Kidwell	Florence Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
yes	W. W. II	218-07-2901	Father - Pasedena, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Thrombosis	2 hrs.
420.1 Antecedent cause(s)		
940 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from March 30, 1950, to March 30, 1950, that I last saw the deceased alive on March 30, 1950, and that death occurred at 5 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
C. Milton Linthicum	M.D.	Linthicum Heights, Md.	3/30/50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	4-2-1950	St Annes	Annapolis Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 2, 1950	[signature]	John W. Taylor Son	Annapolis Md.

33284

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 4 1950
BUREAU

02353

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 149 Monticello Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural give location) 149 Monticello Ave

3. NAME OF DECEASED (Type or Print) (First) Ruby (Middle) Moore (Last) Lamb

4. DATE OF DEATH (Month) 3 (Day) 30 (Year) 1950

5. SEX F.

6. COLOR OR RACE W.

7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~ (Specify)

8. DATE OF BIRTH 6-29-1895

9. AGE last birthday 54 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Bennetsville S. C.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME unknown

14. MOTHER'S MAIDEN NAME unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Reginald C. Lamb Annapolis Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden

94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis — Several years

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 1, 1950, to March 30, 1950, that I last saw the deceased alive on March 30, 1950, and that death occurred at 11.17 m., from the causes and on the date stated above.

SIGNATURE George C Basil (Degree or title) M D ADDRESS Annapolis Md DATE SIGNED 3-31-50

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) DATE THEREOF 4-3-1950 NAME OF CEMETERY OR CREMATORY Naval Academy Cemt. LOCATION (City, town, or county) Annapolis (State) Md

DATE REC'D BY LOCAL REG. April 3, 1950 REGISTRAR'S SIGNATURE [signature] 24. FUNERAL DIRECTOR John M. Taylor-Son ADDRESS Annapolis Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
APR 4 1950
BUREAU V. S.

02354

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH — COUNTY: A.A. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Galesville — LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md — COUNTY: A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Galesville Md
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Fannie (Middle) Margaret (Last) Lee
4. DATE OF DEATH: (Month) Mar (Day) 19 (Year) 1950

5. SEX: Female
6. COLOR OR RACE: White
7. ~~SINGLE, MARRIED~~, WIDOWED, ~~DIVORCED~~ (Specify): widowed
8. DATE OF BIRTH: Oct 31 1859
9. AGE last birthday: 90 yrs. — If under 1 year: Months. Days — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired none
10b. KIND OF BUSINESS OR INDUSTRY: none Hwk.
11. BIRTHPLACE (State or foreign country): Snow Hill Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Uriah Owens
14. MOTHER'S MAIDEN NAME: Dorothy Ann Harper

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT AND ADDRESS: Alma Strong Galesville Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

422.1 Immediate cause (a) arteriosclerotic cardio-vascular disease — 20 yrs.

Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec, 1943, to Mar 19, 1950, that I last saw the deceased alive on Mar 18, 1950, and that death occurred at 5:00 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title): S. Bossuch M.D. — ADDRESS: Annapolis Md — DATE SIGNED: 3/20/50

23. BURIAL, ~~CREMATION~~ ~~MEMORIAL~~ (Specify) — DATE: Mar 21, 1950 — NAME OF CEMETERY OR ~~CREMATORY~~: Quaker Cem — LOCATION (City, town, or county): Galesville (State): Md

DATE REC'D BY LOCAL REG.: Mar 21-1950 — REGISTRAR'S SIGNATURE: W. R. Clayton — 24. FUNERAL DIRECTOR: F. A. Hardesty & Son — ADDRESS: Galesville Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 23 1950
BUREAU V. S.

M

02355

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH · COUNTY: aa — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Md — COUNTY: aa
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Friendship — LENGTH OF STAY (in this place):	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Friendship
HOSPITAL OR INSTITUTION OR STREET ADDRESS:	STREET ADDRESS (If rural, give location): Md

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Susan Ethel Leitch (Leitch)			4. DATE OF DEATH (Month) (Day) (Year): 3 26 1950		
5. SEX: F	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W	8. DATE OF BIRTH: 8/27/96	9. AGE last birthday: 53 yrs.	If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic	10b. KIND OF BUSINESS OR INDUSTRY: Home		11. BIRTHPLACE (State or foreign country): aa Co	12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME: John Crosby			14. MOTHER'S MAIDEN NAME: Hattie Harrison		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If year, give war or dates of service)	16. SOCIAL SECURITY NO.: —		17. INFORMANT AND ADDRESS: Mrs Hattie Harrison Crosby		

18. MEDICAL CERTIFICATION — Friendship, Md

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	12 hr
331 Antecedent cause(s)		
83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension	10 yrs
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —	19b. MAJOR FINDINGS OF OPERATION: —	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify): —	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): —	(CITY OR TOWN) (COUNTY) (STATE): —
TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from ....., 1929, to 3/26, 1950, that I last saw the deceased alive on 3/26, 1950, and that death occurred at 8 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H Howard Owing Md

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: 3/28/50	NAME OF CEMETERY OR CREMATORY: Friendship, Md	LOCATION (City, town, or county) (State): Friendship, Md
DATE REC'D BY LOCAL REG.: Mar 26 1950	REGISTRAR'S SIGNATURE: Grace L. Hutchins	24. FUNERAL DIRECTOR: Wm H. Hutchins	ADDRESS: Owings, Md

30th 1950 M.R. Clayton

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 3 1950
U. S. BUREAU

02356

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 20

M

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VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY A.A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lothian Md
LENGTH OF STAY (in this place) 1 year
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lothian Md
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Henry (Middle) McPherson (Last) Lyles
4. DATE OF DEATH (Month) Mar (Day) 8 (Year) 1950
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widower
8. DATE OF BIRTH About 1864
9. AGE last birthday 85 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman
10b. KIND OF BUSINESS OR INDUSTRY Textiles
11. BIRTHPLACE (State or foreign country) McKendree Md
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Henry M. Lyles
14. MOTHER'S MAIDEN NAME Annie Tongue Md
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY No. None
17. INFORMANT AND ADDRESS James Todbott Lothian Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1 Immediate cause (a) Broncho-pneumonia

Antecedent cause(s)

94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary disease + arteriosclerosis.

(c) (general).

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 10, 1949, to March 8, 1950, that I last saw the deceased alive on March 8, 1950, and that death occurred at 9:30 49 a.m., from the causes and on the date stated above.

SIGNATURE Emily H. Wilson (Degree or title) M.D. ADDRESS Lothian, Md. DATE SIGNED 3/9/50

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL
DATE 3-13-50
NAME OF CEMETERY OR CREMATORY Mt. Pleasant
LOCATION (City, town, or county) NEWARK (State) N.J.
DATE REC'D BY LOCAL REG. Mar 11-1950
REGISTRAR'S SIGNATURE W.R. Clayton Deputy Reg
24. FUNERAL DIRECTOR D.A. Stardisky + Son Galesville Md ADDRESS

29879

RECEIVED
MAR 13 1950
BUREAU V. R.

02357

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH · COUNTY: Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville — LENGTH OF STAY (in this place): 9 months	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital	STREET ADDRESS (If rural, give location): 1910 Mosher St.,

3. NAME OF DECEASED (Type or Print)	(First) Clemmie	(Middle) E.	(Last) Mack	4. DATE OF DEATH	(Month) 3	(Day) 7	(Year) 1950
5. SEX: Female	6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH: 5/12/83	9. AGE last birthday: 66 yrs.	If under 1 year: Months. Days	If under 24 hrs.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —	10b. KIND OF BUSINESS OR INDUSTRY: —	11. BIRTHPLACE (State or foreign country): Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.				
13. FATHER'S NAME: Daniel Christopher	14. MOTHER'S MAIDEN NAME: Lonesome						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If year, give war or dates of service) —	16. SOCIAL SECURITY NO.: —	17. INFORMANT AND ADDRESS: Hospital Records					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Hemorrhage

306X Antecedent cause(s) (b) Hypertension

83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Psychosis with Cerebral Arteriosclerosis — Known to us since adm. 4/16/49

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —	19b. MAJOR FINDINGS OF OPERATION: —	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify): —	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): —	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 4/16/, 1949, to 3/7/, 1950, that I last saw the deceased alive on 3/7/, 1950, and that death occurred at 2:30 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Jacob Morgenstern M.D.		Crownsville, Maryland	3/7/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	3/10/50	Arbutus Memorial Park	Baltimore	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
3/7/50	A. W. Hedrick	William A. Jackson	916 Penna ave

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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02358

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (in this place) 6 weeks
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY St. Mary's
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Beechville
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Lottie (Middle) R. (Last) Medley
4. DATE OF DEATH (Month) 3 (Day) 2 (Year) 1950
5. SEX Female
6. COLOR OR RACE Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH 3/4/84
9. AGE last birthday 65 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Chronic myocarditis	1/12/50
422.2 Antecedent cause(s)		Known to us since adm.
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Senile Psychosis	1/12/50
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 12, 1950 to March 2, 1950, that I last saw the deceased alive on March 2, 1950, and that death occurred at 2:30 P.m., from the causes and on the date stated above.

SIGNATURE [signature] (Degree or title) ADDRESS Crownsville, Maryland DATE SIGNED 3/2/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE 3-7-50 NAME OF CEMETERY OR CREMATORY Arbutus Memorial LOCATION (City, town, or county) Balto (State) Md

DATE REC'D BY LOCAL REG. 3/7/50 REGISTRAR'S SIGNATURE H.W. Hedrick Jr.
24. FUNERAL DIRECTOR Rayner Sanders ADDRESS 1412 E. Preston St

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

02359

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY A.A. Co. Md — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rockhill Beach

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md — COUNTY A.A. Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural, give location) Rockhill Beach Md

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Margaret	J.	Miller	3	5	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	Married	January 9 1895	55 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Housewife	Baltimore Md.	U.S.A.

13. FATHER'S NAME John J. Flanigan — 14. MOTHER'S MAIDEN NAME Delia B. Tierney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. — 17. INFORMANT Mr. Edward F. Miller

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

153 Immediate cause (a) Heart Failure — 3 days.

462 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma Cecum — 2 years

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Degenerative Cardio Vascular Illness

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
J. Brady Smith	M.D.	Riviera Beach Md.	3/6/50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	3/8/50	Cathedral	Baltimore	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
3/7/50	R. W. Hedges	Flynn & Fleming	1426 Light St.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02360

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General Hosptial

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN West Annapolis
STREET ADDRESS (If rural, give location) 311 Severn Ave.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) CHARLOTTE NEIDA

4. DATE OF DEATH (Month) (Day) (Year) 3- 26 1950

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH 3-21-1891

9. AGE last birthday 59 yrs. If under 1 year Months 0 Days 4 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife

10b. KIND OF BUSINESS OR INDUSTRY own

11. BIRTHPLACE (State or foreign country) Hungary

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME unknonw

14. MOTHER'S MAIDEN NAME unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no

16. SOCIAL SECURITY NO. none

17. INFORMANT AND ADDRESS Mr. Joseph H. Neida Husband 311 Severn Ave. West Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Carcinoma generalized	2 years
174 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 48b	(b) Carcinoma Uterus	2 years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis — unknown

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 17, 1950, to March 26, 1950, that I last saw the deceased alive on March 26, 1950, and that death occurred at 4 P m., from the causes and on the date stated above.

SIGNATURE George L Bosil (Degree or title) MD ADDRESS Annapolis Md DATE SIGNED 3-27-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF 3-29-50

NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery

LOCATION (City, town, or county) (State) Annapolis, A.A. Co. Md.

DATE REC'D BY LOCAL REG. March 28, 1950

REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR B.L. Hopping and Son ADDRESS Annapolis, Md.

RECEIVED
MAR 29 1950
BUREAU Y. S.

Evidence for addition of 18 shown on:

FILM No. G 125 APR 14 1950

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

02361

Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Anne Arundel; STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Jessup
LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: House of Correction

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural, give location): 738 Pennsylvania Avenue ✓

3. NAME OF DECEASED (Type or Print): (First) THOMAS (Tommie) (Middle) L. (Last) NELMS

4. DATE OF DEATH: (Month) March (Day) 28 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH: 1920

9. AGE last birthday: 30 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Ga.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: Lillie ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): W. W. #2

16. SOCIAL SECURITY NO.: ?

17. INFORMANT: Md. House of Correction

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

241 Immediate cause (a): Acute and chronic bronchial asthma. (4-14-50 - ams)

112 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b):

(c):

INTERVAL BETWEEN ONSET AND DEATH:

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy* ☒, *Inspection* ☐, *Inquiry* ☐ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE: Emil L. Kraus (Degree or title) M.D. ADDRESS: 700 Fleet Street, Balto., 2, Md. DATE SIGNED: 3-29-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 4/7/50

NAME OF CEMETERY OR CREMATORY: Balto. National

LOCATION (City, town, or county) (State): Balto. Md.

DATE REC'D BY LOCAL REG.: April 5-50

REGISTRAR'S SIGNATURE: A. W. Heduck

24. FUNERAL DIRECTOR ADDRESS: Geo. G. Kelson 1303 Presstman St.

XXX49

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02362

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place): 14 dys
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Anne Arundel General

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Millersville
STREET ADDRESS (If rural give location): Crownsville Post Office

3. NAME OF DECEASED (Type or Print): (First) CHARLES (Middle) E (Last) NEWELL

4. DATE OF DEATH: (Month) March (Day) 13, (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: April 17, 1873

9. AGE last birthday: 76 yrs. — If under 1 year: Months 10 Days — If under 24 hrs.: Hours Min. 8

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor

10b. KIND OF BUSINESS OR INDUSTRY: Pub. School

11. BIRTHPLACE (State or foreign country): Wisc.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-10-0441

17. INFORMANT: Mrs Thersa Newell Wife Crownsville P.O

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) arterio sclerotic heart disease

420.0

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

93d

(b) acute dilatation of heart

(c) gen. arteriosclerosis, bronchopneumonia

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 1st, 1950, to March 13th, 1950, that I last saw the deceased alive on March 13th, 1950, and that death occurred at 3 P m., from the causes and on the date stated above.

SIGNATURE: Edith Roeller (Degree or title) M.D. ADDRESS: 42 State Circle, Annapolis DATE SIGNED: 3-15-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: 3-16-50 — NAME OF CEMETERY OR CREMATORY: Our Lady of the Fields — LOCATION (City, town, or county) (State): Millersville, Md.

DATE REC'D BY LOCAL REG.: March 15, 1950 — REGISTRAR'S SIGNATURE: [signature]

24. FUNERAL DIRECTOR: B.L. Hopping and Son — ADDRESS: Annapolis, Md.

74091

RECEIVED
MAR 16 1950
BUREAU V. S.

02363

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21+25

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie — LENGTH OF STAY (in this place) 35 Years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie
HOSPITAL OR INSTITUTION OR STREET ADDRESS Old Light St. Road	STREET ADDRESS (If rural, give location) Old Light St. Road

3. NAME OF DECEASED (Type or Print) (First) Julia (Middle) (Last) Nicklas			4. DATE OF DEATH (Month) March (Day) 9 (Year) 1950		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH March 25, 1876	9. AGE last birthday 73 yrs.	If under 1 year Months / Days; If under 24 hrs. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work	10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Germany	12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Marie Heline	Route #2 Box23 Glen Burnie, Md.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Occlusion — sudden

420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

94a (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY m.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Gustave H. Pauker M.D.	assistant deputy med examiner	Glen Burnie Md	3/10/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF Mch. 13, 1950	NAME OF CEMETERY OR CREMATORY Glen Haven	LOCATION (City, town, or county) Glen Burnie	(State) Md.
DATE REC'D BY LOCAL REG. 3/10/50	REGISTRAR'S SIGNATURE [signature]	24. FUNERAL DIRECTOR Thomas W. Singleton	ADDRESS Glen Burnie, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
MAR 13 1950
BUREAU T. S.

02364

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General Hosptial

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport
STREET ADDRESS (If rural, give location) 1207 Tyler Ave

3. NAME OF DECEASED (Type or Print) (First) JOSEPH (Middle) S (Last) NORFOLK SR

4. DATE OF DEATH (Month) (Day) (Year) 3- 26-1950 19

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH May 27, 1901
9. AGE last birthday 48 yrs. If under 1 year Months 9 Days 25 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur
10b. KIND OF BUSINESS OR INDUSTRY St. of Maryland
11. BIRTHPLACE (State or foreign country) Anne Arundel Co., Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Mervin Norfolk
14. MOTHER'S MAIDEN NAME Bertha Norfolk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO. none
17. INFORMANT Mr. George M. Norfolk Son 1207 Tyler Ave. Eastport, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Disease	Approx. 40 min.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

420.1
94a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
(CITY OR TOWN) Eastport (COUNTY) A.A. (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) 3-26-50 9:10a m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Natural Causes

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE [signature] (Degree or title) Ass't Med Examiner ADDRESS 3 Chesapeake Ave. Eastport, Md. DATE SIGNED 3-26-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 3-29-50
NAME OF CEMETERY OR CREMATORY St. James Cemetery
LOCATION (City, town, or county) (State) Tracy's Landing A.A. Md.

DATE REC'D BY LOCAL REG. March 28, 1950
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR B.L. Hopping and Son ADDRESS Annapolis, Marylan

420 96

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

36+92

02365

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH· COUNTY Anne Arundle MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Arnold
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hos. Annapolis Md

2. USUAL RESIDENCE (HOME) OF DECEASED· STATE Md. COUNTY A. A. Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Arnold - Md.
STREET ADDRESS (If rural give location) Annapolis - Md.

3. NAME OF DECEASED (Type or Print) (First) CATHERINE (Middle) V (Last) OSTROWSKI
4. DATE OF DEATH (Month) 3 - (Day) 19 - (Year) 1950

5. SEX Female
6. COLOR OR RACE White
7. ~~SINGLE, MARRIED,~~ WIDOWED, ~~DIVORCED~~, (Specify) Stanislaus
8. DATE OF BIRTH 7-15-92
9. AGE last birthday 57 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY Domestic
11. BIRTHPLACE (State or foreign country) Poland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Joseph Marshall
14. MOTHER'S MAIDEN NAME Barbara ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs. Genevieve White - Laughter

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X

Immediate cause (a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 12 days.

93d

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) arteriosclerotic cardiovascular disease

(c) c̄ hypertension.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1948, to 3/18, 1950, that I last saw the deceased alive on 3/19, 1950, and that death occurred at 2:50 P m., from the causes and on the date stated above.

SIGNATURE S. Bossuch M.D. (Degree or title) ADDRESS Annapolis Md DATE SIGNED 3/19/50

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify)
DATE THEREOF 3-23-50
NAME OF CEMETERY OR CREMATORY Holy Rosary
LOCATION (City, town, or county) Baltimore - (State) Md

DATE REC'D BY LOCAL REG. 3-21-50
REGISTRAR'S SIGNATURE
24. FUNERAL DIRECTOR Lilly & Zeiler Inc. ADDRESS 403 S. Wolfe St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

02366

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Rural - Bristol
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Anne Arundel

City or town: Bristol - Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Pindell Station
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Lillian Sunderland Owens

3. (b) Social Security Number

4. Sex: F F

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Elliott Owens

June 15 1875 6.(c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Jany 21st 1876

8. AGE: Years 74 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: Bristol, Maryland
(Town, county, and state)

10. Usual occupation: Hwf

11. Industry or business

FATHER
12. Name: William Sunderland
13. Birthplace: Anne Arundel County

MOTHER
14. Maiden name: Arrie Ellen Dave
15. Birthplace: Bristol, Md.

16. Informant: Owain Elliott Owens

Address: Bristol A A Co Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 14-1950 (month) (day) (year)

Cemetery or crematory: St James

Location: Mt Harwood A A Co Md

18. Funeral director: John M. Taylor Son

Address: Annapolis Md.

19. March 13, 1950 (Date rec'd by registrar) I. B. Dent Mar 16-50 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11 Mar 1950, at 11 15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 Feb 1950 to 11 Mar 1950 and that I last saw her alive on 11 Mar 1950

Immediate cause of death	DURATION
Coronary Thrombosis	30 min
Due to: Hypertensive CVR Disease	2 wk
Due to:	
Other conditions: Hemiplegia	3 wks

420.1
131a
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: R B Lasser M. D.

Address: Upper Marlboro Md Date signed: 12 Mar 50

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M

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RECEIVED
MAR 17 1960
U. S. PATENT OFFICE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02367

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Eastport,
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 833 Bay Ridge Ave

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Eastport,
STREET ADDRESS (If rural, give location): 833 Bay Ridge Ave.

3. NAME OF DECEASED (Type or Print): (First) CAROLINE (Middle) COLLINSON (Last) PHIPPS

4. DATE OF DEATH: (Month) #****%) (Day) 3-22- (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: March 31, 1868

9. AGE last birthday: 86 yrs. — If under 1 year: Months 11, Days 21 — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: own

11. BIRTHPLACE (State or foreign country): Anne Arundel Co. Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Collinson

14. MOTHER'S MAIDEN NAME: Caroline Whittington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Mrs. Phipps 833 Bay Ridge Ave. Eastport

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Myocarditis Chr. with Myocardial Insufficiency	Several years
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	several years
422.1 93d	(c) Arteriosclerosis	years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-1, 1950, to 3.22, 1950, that I last saw the deceased alive on 3.22, 1950, and that death occurred at 1.48 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): George C Boyd M.D. ADDRESS: Annapolis Md. DATE SIGNED: 3.23.50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 3-25-50
NAME OF CEMETERY OR CREMATORY: Friendship Cemetery
LOCATION (City, town, or county) (State): Frendship, A.A. Co. Md.

DATE REC'D BY LOCAL REG.: March 24, 1950
REGISTRAR'S SIGNATURE: [signature]

24. FUNERAL DIRECTOR: B.L. Hopping and Son ADDRESS: Annapolis, Md.

RECEIVED
MAR 27 1950
BUREAU V. S.

02368

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 20

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Deale
LENGTH OF STAY (in this place) Lfs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Deale
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Harry (Middle) F. (Last) Phillips
4. DATE OF DEATH (Month) 3 (Day) 1 (Year) 1950
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH July 3, 1879
9. AGE last birthday 70 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oysterman
10b. KIND OF BUSINESS OR INDUSTRY Catching Oysters
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Benj. Franklin Phillips
14. MOTHER'S MAIDEN NAME Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO. no
17. INFORMANT Ella Phillips

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Hemorrhage — 2 wks.

443x Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive Cardiovascular disease — 1 year

93d (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION None
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) E. Lenhardt — ADDRESS Easport Maryland — DATE SIGNED 3-1-50

23. BURIAL, ~~CREMATION REMOVAL (Specify)~~ Burial
DATE THEREOF Mar 5-1950
NAME OF CEMETERY OR ~~CREMATORY~~ St James
LOCATION (City, town, or county) Tracey (State) Md.
DATE REC'D BY LOCAL REG. Mar 3-1950
REGISTRAR'S SIGNATURE M. R. Clayton Dep. Reg.
24. FUNERAL DIRECTOR V. A. Hardesty & Son
ADDRESS Galesville Md.

15660

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
MAR 6 1950
BUREAU V. S.

Evidence for change of birth date and age shown on:

FILM No. G 124 MAR 17 1950

02369

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH — COUNTY: A. A. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Linthicum
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Nursery Rd + Elinor Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md. — COUNTY: A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: North Linthicum - Rural Balto.
STREET ADDRESS (If rural, give location): 1 Elinor Ave -

3. NAME OF DECEASED (Type or Print) (First) Emma (Middle) Boehl (Last) Pohl
4. DATE OF DEATH (Month) Mar. (Day) 9 (Year) 1950

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow
8. DATE OF BIRTH: July 19 - ~~1889~~ 1888
9. AGE last birthday: 60 61 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk - Bake Shop
10b. KIND OF BUSINESS OR INDUSTRY: Hutzler's Dept Store
11. BIRTHPLACE (State or foreign country): Pa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Phillip Ordwein
14. MOTHER'S MAIDEN NAME: Louisa D. Meyers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If year, give war or dates of service)
16. SOCIAL SECURITY No.: 217-14-0844
17. INFORMANT AND ADDRESS: North Linthicum, Md. Elizabeth E. Ordwein

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
260 X	Immediate cause	(a) Cardio-renal Vascular Disease	16 mos.
61	Antecedent cause(s)	(b) Diabetes	15 yrs.
	Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) General Oedema	1 yr.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 15, 1950, to Mar 9, 1950, that I last saw the deceased alive on ....., 19....., and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Chas. L. Ball Jr. M.D.
ADDRESS: Linthicum Md
DATE SIGNED: 3/9/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE: 3/11/50
NAME OF CEMETERY OR CREMATORY: Baltimore Cemetery
LOCATION (City, town, or county) (State): Baltimore - Md.

DATE REC'D BY LOCAL REG.: March 11th 1950
REGISTRAR'S SIGNATURE: R.W. Hardick
24. FUNERAL DIRECTOR: HENRY SANDER & SONS, INC. BALTIMORE - 13, MARYLAND
ADDRESS:

2664

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02370

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY A. A. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 530 Sixth St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport
STREET ADDRESS (If rural, give location) 530 Sixth St.

3. NAME OF DECEASED (Type or Print): (First) Joseph (Middle) F. (Last) Rawlings
4. DATE OF DEATH: (Month) 3 (Day) 13 (Year) 1950
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)
8. DATE OF BIRTH: 4-9-1874
9. AGE last birthday: 75 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waterman, Crabber
10b. KIND OF BUSINESS OR INDUSTRY: Waterman
11. BIRTHPLACE (State or foreign country): A. A. Co. Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William J. Rawling
14. MOTHER'S MAIDEN NAME: Annie Seible
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs Lillian E. Root. Annapolis Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

422.1 **Immediate cause** (a) Myocarditis Chr. with Myocardial Insufficiency. — Several years

93d **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) — (c) Arteriosclerosis Generalized — several years.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chr Bronchitis — 18 years

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1946, to March 13, 1950, that I last saw the deceased alive on 3-13, 1950, and that death occurred at 5-P m., from the causes and on the date stated above.

SIGNATURE: George C Bond (Degree or title) M.D ADDRESS: Annapolis Md DATE SIGNED: 3-15-50

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify) | DATE THEREOF 3-16-1950 | NAME OF CEMETERY OR CREMATORY: Cedar Bluff | LOCATION (City, town, or county) (State): Annapolis Md

DATE REC'D BY LOCAL REG.: March 16, 1950 | REGISTRAR'S SIGNATURE: [signature] | 24. FUNERAL DIRECTOR: John W. Taylor-Son ADDRESS: Annapolis Md.

15660

VS. A15

RECEIVED
MAR 17 1950
BUREAU V.

02371

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY AA General Hospital MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Franklin Street Annapolis Md.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Davisonville, COUNTY AA MD.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) Sarah (Middle) (Last) Ricks
4. DATE OF DEATH (Month) 3 (Day) 12 (Year) 1950
5. SEX F
6. COLOR OR RACE Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) W
8. DATE OF BIRTH 4-18-1896
9. AGE last birthday 53 yrs. If under 1 year Months 10 Days 12 If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY Domestic
11. BIRTHPLACE (State or foreign country) Davidsonville, Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Emmanuel Thomas
14. MOTHER'S MAIDEN NAME Georginia Tongue Thomas
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mr. Thomas Thomas

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1 Immediate cause (a) myocardial failure due to

940 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) arteriosclerotic coronary disease

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1949, to 3-12, 1950, that I last saw the deceased alive on 3-12, 1950, and that death occurred at 12:30 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Emily H. Wilson, M-D. ADDRESS Lothian, Md. DATE SIGNED 3-12-50

23. BURIAL, CREMATION REMOVAL (Specify) B
DATE THEREOF March 15, 1950
NAME OF CEMETERY OR CREMATORY Davisonville Cemetery
LOCATION (City, town, or county) (State) Davisonville, Md.

DATE REC'D BY LOCAL REG. March 14, 1950
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR William Reese II, ADDRESS 108 Washington St. Annapolis, Md.

52086

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 15 1950
BUREAU U. S.

02372

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Galesville — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Galesville
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	(First) Leon	(Middle) Marion	(Last) Rose	4. DATE OF DEATH	(Month) March	(Day) 15	(Year) 1950
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Jan.4, 1886	9. AGE last birthday 64 yrs.	If under 1 year Months.	Days	If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber	10b. KIND OF BUSINESS OR INDUSTRY Plumb ing Contrac-	11. BIRTHPLACE (State or foreign country) Wash.D.C.	12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Edward Rose	14. MOTHER'S MAIDEN NAME Jessie Rose						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY No. Self Employed	17. INFORMANT AND ADDRESS Mrs.Bertha M.Rose,Galesville,Md.					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Respiratory failure	1 day
Antecedent cause(s)	(b) Carcinoma of lung.	6 mo.
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Myocardial infarction 4 yrs ago.	

163X

47d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec., 1941, to Mar., 1951, that I last saw the deceased alive on Mar., 19 4th-1950, and that death occurred at 3 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
J.B. Flenn	M.D.	2015 One St.	3-15-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE March 17 '50	NAME OF CEMETERY OR CREMATORY Cedar Hill	LOCATION (City, town, or county) Prince Georges (State) Md.
DATE REC'D BY LOCAL REG. 3/15/19	REGISTRAR'S SIGNATURE Amanda Downey	24. FUNERAL DIRECTOR The S.H.Hines Co.	ADDRESS Washington D.C.

50 Mr. Edward Pollinson 348V9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 17 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02373

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County ANNA ARUNDEL
City or town RURAL - PASADENA
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
ROCKWOOD BEACH
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD County ANNA ARUNDEL
City or town PASADENA - RURAL
(If outside city or town limits, write RURAL and give nearest town)
Street No. ROCKWOOD BEACH
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME ANITA CARROL ROTHAGE

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	WIDOWED

6.(b) Name of husband or wife Pete THOMAS C
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) MARCH 8, 1875

8. AGE: Years 75 | Months 0 | Days 3 | If less than one day ..... hrs. ..... min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own home

MOTHER FATHER
12. Name ? SLATER
13. Birthplace ?

MOTHER
14. Maiden name ANITA ?
15. Birthplace ?

16. Informant Mr. JOHN ROTHAGE (SON)
Address ROCKWOOD BEACH - PASADENA

17. BURIAL Date thereof MARCH 14 '50
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory GLEN HAVEN
Location GLEN BURNIE MD

18. Funeral director HARRY H WITKE
Address 4101 EDMONDSON AVE

19. 3/13 1950 A. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1950 at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10 1950 to March 11 1950 and that I last saw her alive on March 10 1950

Immediate cause of death	DURATION
Heart Failure	3 days
Due to Arteriosclerotic Cardio-Vascular Illness	5 years
Due to Degenerative Cardio-Vascular Illness	5 years
Other conditions	

422.1
93d
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Brady Smith M.D.
M.D. or other
Address Riviera Beach, Md. Date signed 3/11/50

02374

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH: COUNTY A.A. Co. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne ARundel County Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.Co
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Edgewater, Md. (Rural)
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) SARAH JANE (Middle) RYAN (Last)

4. DATE OF DEATH (Month) MAR. (Day) 26 (Year) 1950

5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single | 8. DATE OF BIRTH MAR. 23 1870 | 9. AGE last birthday 80 yrs. | If under 1 year: Months. Days | If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework | 10b. KIND OF BUSINESS OR INDUSTRY None | 11. BIRTHPLACE (State or foreign country) Unknown | 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Unknown | 14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service) | 16. SOCIAL SECURITY No. None | 17. INFORMANT AND ADDRESS A.A. Co Records Calhoun Edgewater Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | INTERVAL BETWEEN ONSET AND DEATH

420.1 Immediate cause (a) Coronary Thrombosis — Moments

Antecedent cause(s)

94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1949, to Mar 26, 1950, that I last saw the deceased alive on Mar 23, 1950, and that death occurred at 11.30 A m., from the causes and on the date stated above.

SIGNATURE M Klewans, Md (Degree or title) ADDRESS Annapolis, Md DATE SIGNED 3/27/50

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify) | DATE Mar 28, 1950 | NAME OF CEMETERY ~~OR CREMATORY~~ Catholic Cem West River | LOCATION (City, town, or county) West River (State) Md

DATE REC'D BY LOCAL REG. March 27, 1950 | REGISTRAR'S SIGNATURE Edward Collenson | 24. FUNERAL DIRECTOR T.A. Stardesty & Son | ADDRESS Galesville Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 31 1950
BUREAU V. S.

02375

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH- COUNTY A. A. Co. MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md. COUNTY A. A. Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Garland Park — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Garland Park
HOSPITAL OR INSTITUTION OR STREET ADDRESS 318 Broadview Blvd.	STREET ADDRESS (If rural, give location) 318 Broadview Blvd.

3. NAME OF DECEASED (Type or Print)	(First) GEORGE	(Middle) R.	(Last) SCHUMAN	4. DATE OF DEATH	(Month) Mar.	(Day) 21	(Year) 1950
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH Nov. 25, 1889	9. AGE last birthday 60 yrs.	If under 1 year Months. Days	If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boiler Helper rtd	10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy	11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME Charles Schuman	14. MOTHER'S MAIDEN NAME Elizabeth Eckert						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)	16. SOCIAL SECURITY No. no	17. INFORMANT AND ADDRESS Mrs. Sadie E. Schuman Linthicum, Md. 318 Broadview Rd.					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Oedema of the Lungs	6 hours
Antecedent cause(s)	(b) Hypertension, Chronic Valvular Disease of the Heart	3 yrs
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Hemoplegia	2 yrs

334x
92d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION —	20. AUTOPSY? Yes ☐ No ☑
21. ACCIDENT SUICIDE HOMICIDE (Specify) no	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	(CITY OR TOWN) — (COUNTY) — (STATE) —
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Jan. 1, 1947, to March 21, 1950, that I last saw the deceased alive on March 21, 1950, and that death occurred at 12:20 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
James S. Bellingslea	M.D	108 Central Ave Glen Burnie Md	March 22, 1950.

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 3/23/50	NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.	LOCATION (City, town, or county) (State) Baltimore, Md.
DATE REC'D BY LOCAL REG. 3/22/50	REGISTRAR'S SIGNATURE A. W. Hedrich	24. FUNERAL DIRECTOR WM. J. TICKNER & SONS	ADDRESS Balto., Md.

60896

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

02376

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 20

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY A. A. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Edgewater
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Edgewater
STREET ADDRESS (If rural give location) Edgewater P. O.

3. NAME OF DECEASED (Type or Print): (First) Norris (Middle) M. (Last) Shaffer
4. DATE OF DEATH: (Month) 3 (Day) 17 (Year) 1950

5. SEX: Male
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)
8. DATE OF BIRTH: 9-14-1873
9. AGE last birthday: 76 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter, Builder (Self)
10b. KIND OF BUSINESS OR INDUSTRY: Contractor (Self)
11. BIRTHPLACE (State or foreign country): Baltimore Co. Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Michael Shaffer
14. MOTHER'S MAIDEN NAME: Harriett Uppercue

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs Allen M. Beals, Edgewater Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

443 **Immediate cause** (a) Myocarditis & Myocardial Dumping — 4 yrs.

93d **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis Generalized — 4 yrs.

(c) Hypertension — 1 year

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chr Bronchitis — unknown

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept., 1946, to March 17, 1950, that I last saw the deceased alive on March 17, 1950, and that death occurred at b.d. m., from the causes and on the date stated above.

SIGNATURE — (Degree or title) — ADDRESS — DATE SIGNED
Geo C Basil — M.D — Annapolis md — 3-19-50

23. BURIAL, CREMATION, REMOVAL (Specify) — DATE THEREOF 3-20-50 — NAME OF CEMETERY OR CREMATORY Davidsonville Cemt — LOCATION (City, town, or county) Davidsonville — (State) Md

DATE REC'D BY LOCAL REG. March 20, 1950 — REGISTRAR'S SIGNATURE Edward Collenson

24. FUNERAL DIRECTOR John W. Taylor, Son — ADDRESS Annapolis Md.

30809

RECEIVED
MAR 24 1950
BUREAU V

Dr. Klawans

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02377

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS A. A. General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Parole, Md
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) Emma (Last) Simmons
4. DATE OF DEATH (Month) Mar. (Day) 28 (Year) 1950

5. SEX Female
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widow
8. DATE OF BIRTH Jan. 14 1894
9. AGE last birthday 56 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Chesterfield, A. A. Co. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Louis Butler
14. MOTHER'S MAIDEN NAME Martha Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS Mrs. Daisy Harrod

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
331X Immediate cause	(a) Cerebral Hemorrhage	1 wk.
83a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Generalized arteriosclerosis	?
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/20, 1950, to 3/28, 1950, that I last saw the deceased alive on 3/27, 1950, and that death occurred at 7 A. m., from the causes and on the date stated above.

SIGNATURE Maurice Klawans, Md (Degree or title) ADDRESS Annapolis, Md DATE SIGNED 3/29/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Mar. 31/50
NAME OF CEMETERY OR CREMATORY Fowler's
LOCATION (City, town, or county) Best Gate (State) Md

DATE REC'D BY LOCAL REG. March 29, 1950
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR J. B. Johnson ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 31 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

02378

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS G. G. Co. General

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) Carvel Hall

3. NAME OF DECEASED (Type or Print): (First) Arabella (Middle) Weedon (Last) Smith
4. DATE OF DEATH: (Month) (Day) (Year) 3-16-1950
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH: (Month) (Day) (Year) 1883
9. AGE last birthday: 66 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: none (Home)
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William B. Burgess
14. MOTHER'S MAIDEN NAME: Elizabeth Morgan
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Chas W. Smith Annapolis Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary disease

420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 94a (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): 3 16 1950 24 m. | INJURY OCCURRED While at work ☐ Not while at work ☑ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: [signature] (Degree or title) ADDRESS: Easton Md DATE SIGNED: Mar-17-1950

23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF: 3-18-1950 | NAME OF CEMETERY OR CREMATORY: Cedar Bluff | LOCATION (City, town, or county) (State): Annapolis Md

DATE REC'D BY LOCAL REG.: March 18, 1950 | REGISTRAR'S SIGNATURE: [signature] | 24. FUNERAL DIRECTOR: John M. Taylor Son ADDRESS: Annapolis Md.

RECEIVED
MAR 22 1950
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02379

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH · COUNTY: Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville — LENGTH OF STAY (in this place): 1 yr 11 mos.	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital	STREET ADDRESS (If rural, give location): 154 Winon Street

3. NAME OF DECEASED (Type or Print)	(First) Sarah	(Middle)	(Last) Smith	4. DATE OF DEATH (Month) 3/27/50 (Day) (Year) 19
5. SEX: female	6. COLOR OR RACE: colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single	8. DATE OF BIRTH: about 1879 ~~not known~~	9. AGE last birthday: 70 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): not known	10b. KIND OF BUSINESS OR INDUSTRY: none	11. BIRTHPLACE (State or foreign country): not known	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: not known		14. MOTHER'S MAIDEN NAME: not known		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS: Hospital Records		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) General Paresis	known since 4/9/48
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

625

30b

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none	19b. MAJOR FINDINGS OF OPERATION: none	20. AUTOPSY? Yes ☐ no No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify): none	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none	(CITY OR TOWN) (COUNTY) (STATE): none
TIME OF INJURY (Month) (Day) (Year) (Hour): none m.	INJURY OCCURRED While at Work ☐ Not While At Work ☐ none	HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from 4/9/48, 19....., to 3/27/50, 19....., that I last saw the deceased alive on 3/27/50, 19....., and that death occurred at 11:15 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Jacob Morgenstern M.D.		Crownsville, Md.	3/27/50

23. BURIAL, CREMATION REMOVAL (Specify): Buried	DATE: 3/31/50	NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetary	LOCATION (City, town, or county) (State): Cumberland Md.
DATE REC'D BY LOCAL REG.: 3/28/50	REGISTRAR'S SIGNATURE: E. F. Joyce Local Reg (Rose Hill)	24. FUNERAL DIRECTOR: Wm. Right, Cumberland, Md.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 30 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02380

CERTIFICATE OF DEATH

Reg. Dist. No. 2/

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Orchard Beach
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 1006 Siskey Road

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Orchard Beach
STREET ADDRESS (If rural, give location): 1006 Siskey Road

3. NAME OF DECEASED (Type or Print): (First) FRANCES (Middle) C (Last) SPICKNALL

4. DATE OF DEATH: (Month) Ma r. (Day) 9, (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow

8. DATE OF BIRTH: May 20, 1858

9. AGE last birthday: 91 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Spicknall

14. MOTHER'S MAIDEN NAME: Marthe Moreland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service):

16. SOCIAL SECURITY No.:

17. INFORMANT AND ADDRESS: Mrs Sheldon, Washington, D.C.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
422.1 Immediate cause	(a) Heart Failure	2 weeks
93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerotic Cardio Vascular Renal	10 years
	(c) Degenerative Cardio - Vascular Renal	10 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): No

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1948, to 3/9, 1950, that I last saw the deceased alive on 3/8, 1950, and that death occurred at 3:00 A.m., from the causes and on the date stated above.

SIGNATURE: J. Brady Smith (Degree or title) M.D. ADDRESS: Riviera Beach, Md. DATE SIGNED: 3/10/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 3/11/50 — NAME OF CEMETERY OR CREMATORY: Western — LOCATION (City, town, or county) (State): Baltimore, Md.

DATE REC'D BY LOCAL REG.: March 11 1950 — REGISTRAR'S SIGNATURE: [illegible]

24. FUNERAL DIRECTOR: William Cook, Inc., 1217 St. Paul St. — ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02381

Reg. Diat. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel Co

City or town: Rural - Bristol, Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Anne Arundel

City or town: Rural - Bristol, Md
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Mc Kendree
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Robert Philip Walker Spriggs

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col	Married

6.(b) Name of husband or wife: Louise Spriggs

6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): June 28, 1887

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
62	9	3		

9. Birthplace: Calvert Co. Md
(Town, county, and state)

10. Usual occupation: Farmer - Tenant

11. Industry or business

FATHER — 12. Name: James Wm Henry Spriggs

FATHER — 13. Birthplace: Calvert Co

MOTHER — 14. Maiden name: Caroline Cartee

MOTHER — 15. Birthplace: Calvert Co

16. Informant: Louise Spriggs

Address: Lothian, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-4-50 (month) (day) (year)

Cemetery or crematory: Peters Chapel

Location: Calvert

18. Funeral director: P. E. Sewell

Address: Prince Frederick, md

19. Mar 6 1950 (Date rec'd by registrar) J B Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1 Mar 1950, at 7 00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 Mar 1950 to 1 Mar 1950 and that I last saw h. alive on 1 Mar 1950

	DURATION
Immediate cause of death: Bilat. Bronchopneumonia	3 days
Due to: Influenza	7 days
Due to:	
Other conditions: HBP 338	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert B Spriggs M.D. M. D. or other

Address: Upper Marlboro Md Date signed: May 1, 1950

RECEIVED
MAR 9 1950
BUREAU V. S.

02382

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis (Rural) LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Mulberry Hill Annapolis
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) Mollie (Last) Stansbury

4. DATE OF DEATH (Month) March (Day) 16 (Year) 1950

5. SEX Female | 6. COLOR OR RACE Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH 1862 | 9. AGE last birthday 88 yrs. | If under 1 year Months Days | If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Md. | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME William E Ireland | 14. MOTHER'S MAIDEN NAME Elizabeth Porter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebro vascular Accident

331 X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

83a (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-13, 1949, to 3-16, 1950, that I last saw the deceased alive on 3-15, 1950, and that death occurred at 9 45 P m., from the causes and on the date stated above.

SIGNATURE G. T. Collins (Degree or title) M D ADDRESS 16 Carroll DATE SIGNED 3-17-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE THEREOF March 19, 1950 | NAME OF CEMETERY OR CREMATORY Broadneck | LOCATION (City, town, or county) Skidmore, Md. (State)

DATE REC'D BY LOCAL REG. March 17, 1950 | REGISTRAR'S SIGNATURE [signature] | 24. FUNERAL DIRECTOR J. B. Johnson, Annapolis, Md. ADDRESS

52086

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 20 1950
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02383

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U.S.Naval Hospital, Annapolis

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: RURAL - Gambrills
STREET ADDRESS (If rural, give location): General Delivery

3. NAME OF DECEASED (Type or Print): (First) Charles (Middle) Walters (Last) STEVENSON

4. DATE OF DEATH: (Month) 3 (Day) 2 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White-US

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED

8. DATE OF BIRTH: 5-21-1883

9. AGE last birthday: 66 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S.Navy

10b. KIND OF BUSINESS OR INDUSTRY: CDR, Retired

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Deceased

14. MOTHER'S MAIDEN NAME: Deceased

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If year, give war or dates of service): WW I

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331K 830

Immediate cause (a) CEREBRAL HEMORRHAGE — Interval between onset and death: 3 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) ARTERIAL HYPERTENSION — Years

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from December 1, 1949, to March 2, 1950, that I last saw the deceased alive on March 2, 1950, and that death occurred at 6:40 P m., from the causes and on the date stated above.

SIGNATURE: G.M. DAVIS (Degree or title): CDR, MC, USN ADDRESS: U.S.Naval Hospital, Annapolis, Md. DATE SIGNED: 3-2-50

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — DATE: MAR. 6, 1950 — NAME OF CEMETERY OR CREMATORY: ARLINGTON — LOCATION (City, town, or county): ARLINGTON (State): VA.

DATE REC'D BY LOCAL REG. 3/3/50 — REGISTRAR'S SIGNATURE:

24. FUNERAL DIRECTOR: Thomas W. Singleton — ADDRESS: Glen Burnie, Md.

60896

RECEIVED
MAR 7 1950
BUREAU U. S.

Evidence for change of age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02384

CERTIFICATE OF DEATH

Reg. Dist. No. 20

FILM No. G 12 MAR 16 1950

1. PLACE OF DEATH: COUNTY AA; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lothian, Mt. Zion; STATE MARYLAND; LENGTH OF STAY (in this place) Life; HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Lothian, Md.; COUNTY AA; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town); STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Mary	Frances	Swann	3	5	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
Female	Negro	W.	June 17, 1858	92 91 yrs.	9	4		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Nathinel Evans

14. MOTHER'S MAIDEN NAME Martha Simms

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
4434 Immediate cause	(a) Cardiac Failure	3 days
93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertensive Cardio-Vascular Disease	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/4/50, 19....., to 3/5/50, 19....., that I last saw the deceased alive on 3/5/50, 19....., and that death occurred at 2 A. m., from the causes and on the date stated above.

SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED

Theodore H. Johnson M.D. 40 Northwest St. Annapolis, Md. 3/5/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
B	March 8, 50	Zion Cemetery	Lothian	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 8, 1950	H.R. Clayton Dep Asst Reg	William Reese II	108 Wash. St. Annapolis, MD.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 13 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02385

CERTIFICATE OF DEATH

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brooklyn Park | LENGTH OF STAY (in this place) 17 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 113 Third Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brooklyn Park (Balto. 25)
STREET ADDRESS (If rural give location) 113 Third Avenue

3. NAME OF DECEASED (Type or Print): (First) Alice (Middle) W. (Last) Thompson
4. DATE OF DEATH: (Month) March (Day) 30 (Year) 1950
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: Oct. 14 1860
9. AGE last birthday: 89 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: at Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: (?) Lard
14. MOTHER'S MAIDEN NAME: (?) (?)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No - | (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Ethel R. Bailey (Niece)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
420.0 Immediate cause	(a) Acute Myocardial Infarction	2 hrs
93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Acute Coronary Thrombosis	?
	(c) Arteris - Sclerotic Hypertensive Heart Disease	10 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing deatb.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 15, 1949, to March 30 1950, that I last saw the deceased alive on 3/30, 1950, and that death occurred at 8:10 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Benjamin Budiansky MD 5004 Ritchie Highway March 31, 1950

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF Mon. Apr. 3 1950 | NAME OF CEMETERY OR CREMATORY Loudon Park Cem. | LOCATION (City, town, or county) (State) Balto., Md.

DATE RECD BY LOCAL REG. 3/31/50 | REGISTRAR'S SIGNATURE P. W. Redmond DR | 24. FUNERAL DIRECTOR ADDRESS J. Howard Evans 1400 S. Charles St. - Balto. 30 Md.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02386

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linthicum Heights
LENGTH OF STAY (in this place) 2 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 807 S. Fort Meade Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Balto.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN English Consul
STREET ADDRESS (If rural, give location) Box 403

3. NAME OF DECEASED (Type or Print): (First) OSWALD (Middle) ROBERT (Last) VOIGT
4. DATE OF DEATH: (Month) March (Day) 11 (Year) 1950
5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED
8. DATE OF BIRTH: Nov. 21, 1889
9. AGE last birthday: 60 yrs. — If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): never worked
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Gustav Voigt
14. MOTHER'S MAIDEN NAME: Caroline Molsox
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If year, give war or dates of service): World #1
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS: Mrs. Frieda Voigt, 807 Camp Meade Rd. Linthicum Hgts, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

443 Immediate cause (a) Cerebral hemorrhage — 7 hrs.

Antecedent cause(s)

934 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertension — ?

(c) Congestive heart failure — @ 3 wks.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar. 5, 1950, to Mar. 11, 1950, that I last saw the deceased alive on Mar. 11, 1950, and that death occurred at 2:30 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED
C. Milton Linthicum, M.D. — Linthicum Heights, Md. — Mar. 11, 1950.

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE: 3/14/50
NAME OF CEMETERY OR CREMATORY: Balto. National Cem.
LOCATION (City, town, or county) (State): Balto., Md.

DATE REC'D BY LOCAL REG. 3/14/50
REGISTRAR'S SIGNATURE: Wm. Hedrick Dep
24. FUNERAL DIRECTOR: WM. J. TICKNER & SONS — ADDRESS: Balto., Md.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02387

Reg. Dist. No. 31

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Severna Park (Rural) — LENGTH OF STAY (in this place): 24 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Ceder Crest Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Harmons
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Clara	Louise	Waltz	March	4	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	White	Widow	April 16, 1869	80 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
~~None~~ Housework	Home None	Port Corbin Penna	US

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles Krater	Sarah Bockman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	
No	none	Mrs. Sallie Steel	8049 Moro Street Philadelphia, Pa.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Mitral Insufficiency	3 months
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) General arteriosclerosis	?
	(c) General debilenia	?

II. OTHER SIGNIFICANT CONDITIONS
Coodition contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from Dec., 1950, to March 3 d., 1950, that I last saw the deceased alive on March 3, 1950, and that death occurred at 7 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Gustave A. Rauben M.D.		Glen Burnie,	3/6/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Mch. 7, 1950	Friendship, A.A.Co. Md	Anne Arundel Co.,	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
3/6/50		Thomas W. Singleton,	Glen Burnie, Md.

RECEIVED
MAR 9 1950

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02388

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A16-1

1. PLACE OF DEATH: COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville
LENGTH OF STAY (in this place): 1 mos. 3 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Balt. City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural, give location): not known

3. NAME OF DECEASED (Type or Print): (First) Richard (Middle) C. (Last) Wheeler

4. DATE OF DEATH: (Month) 3/4/50 (Day) (Year) 19

5. SEX: male

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): not known

8. DATE OF BIRTH: about 1892

9. AGE last birthday: 57(?) yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): not known

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): not known

12. CITIZEN OF WHAT COUNTRY? ?

13. FATHER'S NAME: not known

14. MOTHER'S MAIDEN NAME: not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): ******

16. SOCIAL SECURITY No.: ******

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0 **Immediate cause** (a) Generalized Arteriosclerosis — Interval Between Onset and Death: known since 2/1/50

97 **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: ****** — 19b. MAJOR FINDINGS OF OPERATION: ***** — 20. AUTOPSY? Yes [X] No [ ]

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): ******** — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ****** — (CITY OR TOWN): ******** — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: ********** — INJURY OCCURRED While at Work [ ] Not While At work [ ] — HOW DID INJURY OCCUR? ********

22. I hereby certify that I attended the deceased from 2/1/50, 19..., to 3/4/50, 19..., that I last saw the deceased alive on 3/4/50, 19..., and that death occurred at 1:55 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): Jacob Shapleigh M.D. — ADDRESS: Crownsville, Md. — DATE SIGNED: 3/6/50

23. BURIAL, CREMATION, REMOVAL (Specify) — DATE: 3/9-50 — NAME OF CEMETERY OR CREMATORY: Hospital — LOCATION (City, town, or county) (State): Crownsville Md

DATE REC'D BY LOCAL REG. 3/9/50 — REGISTRAR'S SIGNATURE: E. F. Joyce Local Reg. — 24. FUNERAL DIRECTOR — ADDRESS: Supt Hospital Crownsville Md

RECEIVED
MAR 13 1950
BUREAU A. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02389

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie
STREET ADDRESS (If rural, give location) 422 Third Ave., S.W.

3. NAME OF DECEASED (Type or Print) (First) Hulda (Middle) (Last) Wilks

4. DATE OF DEATH (Month) March (Day) 5 (Year) 1950

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow

8. DATE OF BIRTH Apr. 3 1873

9. AGE last birthday 76 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ~~None~~ Housework

10b. KIND OF BUSINESS OR INDUSTRY ~~None~~ Home

11. BIRTHPLACE (State or foreign country) Germany

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Andree Reinhart

14. MOTHER'S MAIDEN NAME Wilhelmina (Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY No. NONE

17. INFORMANT Mrs. Herman Wilks, 422 Third Ave, S.W. Glen Burnie, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Mitral Insufficiency	1 1/2 y.
260X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Interstitial nephritis	1 1/2 y.
61	(c) Diabetes	2 y. +

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility

19a. DATE OF OPERATION —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) NO

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from May, 1950, to March 4, 1950, that I last saw the deceased alive on 3/4, 1950, and that death occurred at 8.30 PM m., from the causes and on the date stated above.

SIGNATURE Gustave H. Pauker (Degree or title) ADDRESS Glen Burnie, Md. DATE SIGNED 3/6/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF Mar. 8, 1950

NAME OF CEMETERY OR CREMATORY Ceder Hill

LOCATION (City, town, or county) Brooklyn (Rural) (State) Md.

DATE REC'D BY LOCAL REG. 3/6/50

REGISTRAR'S SIGNATURE L. J. De Alba

24. FUNERAL DIRECTOR Thomas W. Singleton ADDRESS Glen Burnie, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 9 1950

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02390

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Friendship; LENGTH OF STAY (in this place) 3 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Friendship; STREET ADDRESS (If rural, give location) —

3. NAME OF DECEASED (Type or Print): (First) Anna; (Middle) —; (Last) Winters

4. DATE OF DEATH: (Month) Mar. (Day) 11 (Year) 19-50

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W

8. DATE OF BIRTH: Mar. 2, 1881

9. AGE last birthday: 69 yrs. If under 1 year: Months. 0 Days 10 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Albert Winters

14. MOTHER'S MAIDEN NAME: Rebecca Wuchter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.: No

17. INFORMANT AND ADDRESS: Olive Rohrer - Friendship, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Hemorrhage	3/11/50
443 Antecedent cause(s)	(b) Hypertensive Cardiovascular Disease	1949
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —; PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY: —; (CITY OR TOWN): —; (COUNTY): —; (STATE): —

TIME OF INJURY (Month) (Day) (Year) (Hour): — m.; INJURY OCCURRED While at Work ☐ Not While At work ☐; HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 2/25, 19 50, to Mar 11, 19 50, that I last saw the deceased alive on 2/25, 19 50, and that death occurred at 3 p.m., from the causes and on the date stated above.

SIGNATURE Paul E. Stone (Degree or title) ADDRESS Frederick DATE SIGNED —

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Mar. 14, 1950	Rest Haven Cem.	Centerville Penna.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
3/11/50	N. H. Hord	A. A. Harkness & Son - Mutual, Md.	

RECEIVED
MAR 20 1950
BUREAU Y S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02391

CERTIFICATE OF DEATH

Reg. Dist. No. 27

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Ft George G Meade, Md.
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Station Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Balto.
STREET ADDRESS (If rural give location): 1630 Ceddox

3. NAME OF DECEASED (Type or Print): (First) NORMA (Middle) Maria (Last) WRIGHT

4. DATE OF DEATH: (Month) March (Day) 3 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Nov. 19-1949

9. AGE last birthday: yrs. If under 1 year: Months 3 Days — If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): A.A.Co. Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Norman Wright

14. MOTHER'S MAIDEN NAME: Josephine Szandrowski

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT:

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Tracheo-Bronchitis, with circulatory collapse

501 X

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

106c

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2200 hrs 3 Mar., 1950, to 2345 Hrs 3 Mar., 1950 that I last saw the deceased alive on Mar 3, 1950, and that death occurred at 2345 hrs., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

James S. Mitchener Jr

JAMES S. MITCHENER, JR MD Sta Hosp Ft Geo G Meade, Md. March 4, 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: Mar 6-1950

NAME OF CEMETERY OR CREMATORY: Holy Cross

LOCATION (City, town, or county) (State): A.A. Co.

DATE REC'D BY LOCAL REG.: 6 Mar 50

REGISTRAR'S SIGNATURE: C. W. Hedrich

24. FUNERAL DIRECTOR — ADDRESS: FIALKOWSKI FUNERAL HOME 2007 Eastern Ave Balto, Md.

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